Reproductive FERTILITY
Peyman Saadat M.D. Inc. (dba) Sami Jabara M.D.
Ira A. Blitz M.D. Ellen H. Goldstein M.D.

REGISTRATION & ASSIGNMENT OF BENEFITS

You are here to see : ☐ Dr. Peyman Saadat

☐ Dr. Sami Jabara

PATIENT INFORMATION	Last Name_____ First Name_____ Street Address_____ City_____ State_____ Zip Code_____ Phone# Home_____Cell_____Work_____ Email _____ Sex ☐ M ☐ F Age_____ Birth Date_____ Social Security #_____ Driver's License#_____ Status ☐ Single ☐ Married/Domestic Partner ☐ Other_____
PATIENT CONTACT INFORMATION	***Permission to leave messages?*** Home Phone_____ ☐ Yes ☐ No Cell Phone_____ ☐ Yes ☐ No Work Phone_____ ☐ Yes ☐ No Email_____ ☐ Yes ☐ No ***In case of emergency:*** Contact Person_____ Relationship_____Phone_____ Primary Care Physician_____Phone_____ When it becomes necessary to contact you by phone, please list the number(s) where you wish us to call. May we leave messages such as lab results, appointments or other medical information on an answering machine, or with another person who answers the phone, at that number? ☐ Yes ☐ No

X_____ _____ _____

Signature of Patient (or Guardian) Name of Guardian, if applicable Date

PATIENT EMPLOYMENT INFORMATION	Occupation:_____ ☐ Full Time ☐ Part Time ☐ I am not employed Employer/ Company Name_____ Employer Address_____ City_____ State_____ Zip Code_____ Employer Phone_____ Do you have HSA (Health Savings Account, often through employer)? Yes ☐ No ☐
PURPOSE OF VISIT	Is your office visit related to infertility: ☐ Yes ☐ No Please state below the reason for your office visit: _____ _____ _____
SPOUSE OR PARTNER INFORMATION	Last Name_____ First Name_____ Street Address_____ City_____ State_____ Zip Code_____ Home Ph.# _____Cell/Alt Ph.# _____
	Sex ☐ M ☐ F Age_____ Birth Date_____ Social Security #_____ Driver's License#_____ Status ☐ Single ☐ Married/Domestic Partner ☐ Other_____ Occupation:_____ Employer/ Company Name:_____
PATIENT PHARMACY INFORMATION	Pharmacy Name:_____ Street Address_____ City _____State _____Zip Code_____ Pharmacy Phone Number :_____

X_____ _____ _____

Signature of Patient (or Guardian) Name of Guardian, if applicable Date

REFERRAL INFORMATION

How did you learn about this practice: _____

Referring physician Name:_____

Personal Physician Name:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Persian Radio ☐ Yes ☐ No

Advertisement ☐ Yes ☐ No

Newspaper/Magazine ☐ Yes ☐ No _____

Website ☐ Yes ☐ No _____

Friend/Family Name: _____

Other ☐ Yes ☐ No (Please be Specific) _____

_____

☐ I have no insurance

Insurance Plan_____

Policy/ Group# _____Effective Date_____

Name of Insured_____

Relationship to Patient ☐ Self ☐ Spouse/Partner ☐ Parent ☐ Other_____

If not Self: _____

Insured's Birth Date_____ Social Security # _____

Insured's Employer _____Employer's Phone_____

Employer Address_____

_____

Insurance Plan_____

Policy/Group # _____ Effective Date_____

Name of Insured _____ID#_____

Relationship to Patient ☐ Self ☐ Spouse/ Partner ☐ Parent ☐ Other_____

X_____ _____ _____

Signature of Patient (or Guardian) Name of Guardian, if applicable Date

PATIENT AGREEMENT & AUTHORIZATION FOR THE RELEASE OFMEDICALAND HEALTH PLAN DOCUMENTS FOR THE CLAIMS PROCESSING & REIMBUSEMENT ASREQUIRED BY FEDERAL & STATE LAWS

LEGAL ASSIGNMENT OF BENEFITS & DESIGNATION OF AUTHORIZATION REPRESENTATIVE

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage and have provided this information to Reproductive Fertility Center. I hereby assign and convey directly to Reproductive Fertility Center (hereinafter referred to as **"Provider"**), as my designated authorized representative, including but not limited to its designation as my ERISA representative, all medical benefits and insurance reimbursement payable to me for services rendered from Provider, regardless of Provider's managed care network participation status. I understand and agree that I am legally responsible for any and all actual total charges authorized by me, regardless of any applicable insurance or benefits payments. I hereby authorize Provider to release all medical information necessary to process my claims, under the HIPAA rules. I hereby authorize my plan administrator fiduciary, insurer, and attorney to release to Provider any and all plan documents, summary benefit description, insurance policies, and/ or settlement information upon written request from Provider in order to claim medical benefits, I authorize the use of this signature on all my insurance and/ or employee health benefits claim submissions. I hereby assign and convey to Provider, to the full extent permissible under the laws, including but not limited to, ERISA 502(a)(1)(B) and 502 (a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any legal or administrative claim, benefit claim, liability or tort claim, chose to action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from Provider, including any right to pursue those legal or administrative claims or chose in action. This contributes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and administrative claims. I hereby assign and covey to Provider, to the full extent permissible under the laws, to claim or lien such medical benefits, settlement, insurance, reimbursement and any applicable remedies, including rights to any settlement, or applicable legal or administrative remedies, including damages arising from ERISA breach of fiduciary duty claims. These include, but are not limited to, (1) obtaining information about the claim to the same extent as I could obtain; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, providing, or receiving notice about appeal proceedings; and (5) participating in any administrative and judicial actions by Provider to pursue such claim, chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, and/or plan administrator. This may include, if necessary, bringing suit by Provider against any such liable party in my name with derivative standing but at its own expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable Federal and State laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

X _____ _____ _____

Signature of Patient (or Guardian) **(if applicable)** | Name of Guardian | Date

THANK YOU

Reproductive FERTILITY
Peyman Saadat M.D. Inc. (dba) Sami Tabara M.D.
Ira A. Blitz M.D. Ellen H. Goldstein M.D.

Assignment of Benefits

I hereby authorize my Insurance Company to pay by check made payable and mailed directly to:

Peyman Saadat M.D.
Reproductive Fertility Center
269 S. Beverly Dr. #644
Beverly Hills, CA 90212

for the medical and surgical benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charge for services rendered. I understand that as a courtesy to me, Reproductive Fertility Center will file a claim with my insurance company on my behalf. I understand that Dr. Saadat or his associates may use facilities or associate with other physicians that are not in network with your insurance carrier. If your insurance plan does not provide out of network benefits I understand that I will be fully responsible for any balances arising from such services. I am financially responsible for, and hereby do agree to pay, in a current manner, any charges not covered by the insurance. If it is necessary to file a formal collection action, I agree to pay all costs, including reasonable attorney's fees incurred.

X_____

Patient Signature or Responsible Person Date

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HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage tour health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities, training of medical students, licensing, marketing, and fund raising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical schools students that see patients in our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military activity and National Security: Worker's Compensation: Inmates: Required Uses and disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses of Disclosures Will Be Made only With Your Consent, Authorization or opportunity to Object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

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HIPPA NOTICE OF PRIVACY PRACTICES

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use a civil, criminal or administrative action or proceeding, and protected health information the is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclose of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with is and we may prepare to rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made. If any of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint**. We will not retaliate against you for filing a complaint.**

THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON/OR BEFORE APRIL 14, 2003.

We are required by law to maintain the privacy of , and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by telephone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

_____ _____
Print Name: Date:

_____ _____
Signature: Witness:

Reproductive FERTILITY
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Ira A. Blitz M.D.
Sami Tabara M.D.
Ellen H. Goldstein M.D.

DECLARATION OF VOLUNTARY PARTICIPATION AND ABSENCE OF SOLICITATION

We, _____ (female patient) and _____ (partner) hereby declare that we are obtaining infertility and any infertility or obstetric or gynecological related treatment(s) voluntarily from physician Peyman Saadat, M.D. out of our own free will and without any solicitation from Dr. Peyman Saadat or any of his associates, employees, employer or agents.

_____ _____
Initial Initial

We also declare that we voluntarily sought out Dr. Peyman Saadat for his medical services WITHOUT ANY SOLICITATION OR INDUCEMENT of anyone or any entity.

_____ _____
Initial Initial

We chose Dr. Peyman Saadat as out physician as a personal choice, and were not solicited to leave any other physician or practice in any way or by anyone or any entity.

_____ _____
Initial Initial

_____ _____ _____
Patient Name Patient Signature Date

_____ _____ _____
Patient Name Patient Signature Date

_____ _____
Witness Date

Main Office
9201 W. Sunset Blvd, Suite 500
West Hollywood, CA 90069
tel: 310.278.7590 fax: 310.278.7599

Burbank Office
500 East Olive Ave, Suite 320
Burbank, CA 91501
tel: 818.238.9292 fax: 818.238.9296

Diamond Bar Office
23525 Golden Springs Dr, Suite D
Diamond Bar, CA 91765
tel: 909.861.7840 fax: 909.861.7850

Riverside Office
9448 Magnolia Ave, Suite 103
Riverside, CA 92503
tel: 951.352.0770 fax: 951.352.4770

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AUTHORIZATION FOR DISCLOSURE AND USE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

I hereby authorize: _____
Physician/ Healthcare Facility
to release information regarding my medical history, illness or injury, consultations, prescriptions, treatment, diagnosis or prognosis, including X-rays, correspondence and/or medical records including those from other healthcare providers that the above named healthcare provider may hold, means of mail, fax or any other electronic methods.

To: _____
Name
_____
Address
_____ _____ _____
City State Zip Code

The medical information/records will be used for the following purpose: _____
This authorization is:
[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medial information: _____
_____.

I also consent to the specific release of the following records:
Drug/Alcohol/Substance Abuse _____ (Initial) HIV Diagnosis/Treatment _____ (Initial)
Psychiatric/Mental Health _____ (Initial) Genetic Information _____ (Initial)
Tests for Antibodies to HIV _____ (Initial)

DURATION: This authorization shall be effective immediately and remain in effect until _____
Date
RESTRICTIONS: Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my rights to receive a copy of this authorization.

_____ _____
Signature of patient or *legal/personal representative* Relationship *if other than patient*

_____ _____ _____
Patient Name (PLEASE PRINT) Patient date of birth Patient Social Security #

_____ _____ _____
Date Witness name Witness signature