OLINA E. HARWER, M.D., F.A.A.F.P. / PARTNERS IN HEALTH
32241 Camino Capistrano, Suite A105San Juan Capistrano, CA 92675
Phone: (949)661-6555 Fax: (949)661-8269

I was referred by:_____ Today's Date:_____

PATIENT INFORMATION **E-Mail Address:_____**

Last Name:_____ First Name:_____ Middle Init_____

Date of Birth:_____ Gender: M F Social Security#:_____

Marital Status: Sep Div Mar Sing Wid Driver License#_____ Exp_____ State:_____

Home Phone:_____ Work#:_____Ext_____ Cell#:_____

Home Address:_____

City State ZIP:_____

GUARANTOR INFORMATION (Insured Party / Parent / Guardian)

Last Name:_____ First Name:_____ Middle Init_____

Date of Birth:_____ Gender: M F Social Security#:_____

Marital Status: Sep Div Mar Sing Wid Driver License#_____ Exp_____ State:_____

Home Phone:_____ Work#:_____Ext_____ Cell#:_____

Home Address:_____

City State ZIP:_____

PRIMARY INSURANCE INFO: ***Plan Type: PPO HMO POS Medicare CalOptima MediCal Workers'Comp***

Insurance Company Name:_____

Claims Address:_____

Ins.Co Phone#:_____

Subscriber/Insured's ID#:_____Group#_____

Insured's Name:_____ Birth Date:_____

Relationship to Patient:_____

SECONDARY INSURANCE INFO: ***Plan Type: PPO HMO POS Medicare CalOptima MediCal Workers'Comp***

Insurance Company Name:_____

Claims Address:_____

Ins.Co Phone#:_____

Subscriber/Insured's ID#:_____**Group#**_____

Insured's Name:_____ **Birth Date:**_____

Relationship to Patient:_____

EMERGENCY CONTACT ****NOTE: MUST BE PERSON LIVING OUTSIDE OF YOUR HOME!!!

Name:_____ **Phone:**_____

Address:_____

City State ZIP:_____ **Relationship to Patient:**_____

ASSIGNMENT & RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage as listed above and assign directly to Olina E. Harwer, M.D./Partners In Health all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid/covered by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Further, I certify that the above information is correct, to the best of my knowledge. I will not hold the doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ **Relationship:**_____ **Date:**_____

Responsible Party Signature

FOR MEDICARE RECIPIENTS ONLY: MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Olina E. Harwer, M.D. / Partners In Health for any services furnished by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, coinsurance an any non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

_____ **Relationship:**_____ **Date:**_____

Responsible Party Signature