

**ROBERT A. DE STEFANO, M.D., INC**  
**23501 PARK SORRENTO, SUITE 216**  
**CALABASAS, CA 91302**  
**818 222-7495**

**PATIENT NOTICE OF PRIVACY PRACTICES**

**This notice describes how medical information about you may be disclosed. Please review it carefully.**

Robert A. De Stefano, M.D., Inc. will use your medical information for the following:

1. TREATMENT: Including providing your medical records to consulting clinicians and insurance companies.
2. PAYMENT: Insurance companies may request part or all of your medical record to pay the claim.
3. HEALTH CARE OPERATIONS: Any others involved in your healthcare.

The entire Private Policy Notices of Robert A. De Stefano, M.D., Inc. is posted in the waiting room for your perusal. If you would like to obtain a copy, please ask the front office, and we will gladly provide one for you.

In conjunction with these privacy practices you will need to provide us with the following information:

1. Name of person(s) we may speak to regarding your health (i.e., spouse, child, etc. including phone number)

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2. May we leave a message regarding your health or an upcoming appointment on your answering machine?  
 Yes     No

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Patient's Name or Legal Guardian

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**ROBERT A. DE STEFANO, M.D., INC. 23501 PARK SORRENTO, #216, CALABASAS, CA 91302 (818) 222-7495**

PATIENT NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
First Middle Last

ADDRESS \_\_\_\_\_  
Street / Apt # City State Zip

HOME PHONE (\_\_\_\_) \_\_\_\_\_ CELL PHONE (\_\_\_\_) \_\_\_\_\_ SOCIAL SECURITY NO \_\_\_\_\_

Male  Female DRIVER'S LICENSE \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

HAVE WE SEEN OTHER IMMEDIATE FAMILY MEMBERS? PLEASE LIST: \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

WORK ADDRESS \_\_\_\_\_ WK PHONE (\_\_\_\_) \_\_\_\_\_

INFORMATION REGARDING:  SPOUSE  PARENT/GUARDIAN OF CHILD

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female HOME PHONE: (\_\_\_\_) \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ SSN: \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ WK PHONE: (\_\_\_\_) \_\_\_\_\_

WORK ADDRESS \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

**INSURANCE INFORMATION:**

**THIS OFFICE IS A PROVIDER FOR MEDICARE ONLY. WE ARE NOT A PART OF ANY INSURANCE NETWORK. PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. A SUPERBILL WILL BE PROVIDED TO YOU FOR BILLING YOUR INSURANCE COMPANY. IF YOU NEED CLARIFICATION OF OUR BILLING PROCEDURES, PLEASE CHECK WITH OUR OFFICE STAFF, PRIOR TO BEING SEEN.**

**PLEASE PRESENT YOUR INSURANCE CARD TO COPY AND KEEP ON FILE IN CASE OUTSIDE LAB WORK IS DONE. INFORMATION MAY BE FORWARDED TO THE LABORATORY TO EXPEDITE THEIR BILLING PROCESS.**

PRIMARY INSURANCE COMPANY: \_\_\_\_\_ GROUP NO: \_\_\_\_\_

SUBSCRIBER NO. \_\_\_\_\_ RELATIONSHIP TO SUBSCRIBER:  SELF  SPOUSE  CHILD

SECONDARY INSURANCE COMPANY: \_\_\_\_\_ GROUP NO: \_\_\_\_\_

SUBSCRIBER NO: \_\_\_\_\_ RELATIONSHIP TO SUBSCRIBER:  SELF  SPOUSE  CHILD

REFERRED BY DOCTOR \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

PLEASE READ AND SIGN THE FOLLOWING:

I do hereby authorize and consent to all medical treatment deemed necessary to treat the above patient. I directly assign all benefits to Robert A. De Stefano, M.D., Inc. I hereby authorize Robert A. De Stefano, M.D., Inc. to release all information necessary to secure the payment of benefits. I understand that payment to this office for services rendered is my responsibility regardless of insurance involvement.

\_\_\_\_\_  
 Signature of Patient or Responsible Party

**Robert A. De Stefano, M.D., Inc.**

**FINANCIAL POLICY**

*Our goal is to help you achieve and maintain optimum health for a lifetime. So that we may better serve you, please read and sign this form. We appreciate the confidence you have placed in us as professionals.*

We accept cash, personal checks, Visa, and MasterCard and American Express as payment for services.

Because we are not providers for any insurance company except Medicare, the patient is responsible to this office for payment of services, regardless of insurance coverage. Superbill copies of charges will be provided to the patient for billing to their insurance company. Payment is due at the time services are rendered; deferred surgeries are due within 30 days of statement billing.

Collection action will begin on an account if the balance is not paid within 30 days. If the balance reaches 90 days past due, we will turn your account over to an outside collection agency for further action. The patient will be responsible for any charges incurred in such action.

If a check is returned to the office due to insufficient funds, the original check amount plus a \$10.00 returned check fee must be received within 15 days from the date the check was returned to avoid further late fees or collection action.

Please be aware that some services provided may be non-covered services under your policy. It is the patient's responsibility to be aware of the individual policy restrictions and guidelines. This office will not enter into a dispute with an insurance company, but we can assist you if you are having difficulties.

Note: All laboratory tests, injections, venipunctures, procedures, or any testing that is not included as part of an office visit will result in additional expenses. The laboratory may be a provider for your insurance company. Taking a copy of your insurance information is done as a courtesy to expedite their billing process.

Please help us better serve you and our other patients by keeping all scheduled appointments. If you must change an appointment, please do so within 24 hours of the appointment time. We realize some emergencies cannot be prevented and we allow for missed appointment on occasion. If we are notified late or not at all that an appointment will not be kept more than twice, this office will consider dismissing ourselves from further professional care for your family.

I certify that I have read and understand the "Financial Policies" and agree to all terms and conditions as stated above. I understand that it is my sole responsibility to verify insurance coverage. I also understand that even though I may have health insurance coverage, payment for services is my responsibility. I know that payment for service is due at the time that service is rendered unless other financial arrangements have been made.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_