REGISTRATION (S. Daniel Golshani, M.D., Inc.)

Date_____ Home Phone_____ Cell Phone_____ Work Phone_____

Patient_____Email_____
Last Name, First Name Middle Initial

Address_____City_____State_____ZipCode_____

Sex ☐ M ☐ F Age_____ Birth date_____☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #_____ Driver's License #_____

How and where did you learn about this clinic?_____

EMPLOYER	Company Name_____ Occupation_____ Address_____ Phone_____ City State Zip
EMERGENCY CONTACT	Name_____ Last Name First Name Middle Initial Relationship:_____ Phone:_____ Work Phone:_____ Address_____ City State Zip
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ID #:_____
PATIENT AGREEMENT	LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to **S. Daniel Golshani, M.D., Inc.**., all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from **S. Daniel Golshani, M.D., Inc.**. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to **S. Daniel Golshani, M.D., Inc.** any and all plan documents, insurance policy and/or settlement information upon written request from Avosant Surgical Institute in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named **S. Daniel Golshani, M.D., Inc.** to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chosen action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from **S. Daniel Golshani, M.D., Inc.** and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with **S. Daniel Golshani, M.D., Inc.** in any attempts by **S. Daniel Golshani, M.D., Inc.** to pursue such claim, chosen action or right against my insurers and/or employee health care plan, including, if necessary, filing suit with **S. Daniel Golshani, M.D., Inc.** against such insurers and/or employee health care plan in my name but at **S. Daniel Golshani, M.D., Inc.** expense. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. **Consent to treat:** I, the undersigned, hereby consent to the administration and performance of all diagnostic procedures and treatments which, in the judgment of my physician, may be considered necessary or advisable. **Photo consent:** In connection with the medical services that I am receiving from my physician, Dr. S. Golshani, I consent that photographs may be taken of me or parts of my body, under the following checked conditions: 1. The photographs may be taken only with the consent of my physician and under such conditions and at such times as may be approved by him/her. 2. The photographs shall be taken by my physician or by a photographer approved by my physician. 3. In addition, they may be used in the judgment of my physician for medical research, education, or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose that may be deemed proper in the interest of medical education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name and the photos shall be featured in a very discrete fashion. Please check here to agree to photo consent Please check here if you do not agree to photo consent _____ _____ Signature of Insured / Guardian DATE