**Celina M. Nadelman, M.D.**
Fine Needle Aspiration Specialist
Laboratory Director Precision Aspiration & Biopsy
Tel: (310) 702-6701 Fax: (310) 935-3039

**REGISTRATION FORM**
(please print neatly)

**PATIENT INFORMATION**

**Name**:_____
Last First Middle Initial

**Date of Birth**:_____/_____/_____ **Gender**: _____ **Race/Ethnicity:**_____

**Primary phone number**:(_____)_____ (mobile/home) (circle one)

**Email Address**:_____ **Occupation**: _____

**Home Address**: _____

**City**:_____ **State**:_____ **Zip Code**:_____

**How did you hear about Dr. Nadelman?** _____

**Are you the primary insurance policy holder?** Yes / No **(circle one)**

**If you circled 'no', please indicate primary policy holder name**: _____

Primary policy holder's **date of birth**:_____/_____/_____ Primary Policy holder's **gender**: M/F

**Relationship** to policy holder: _____

Primary policy holder's **phone number**: (_____)_____

Primary policy holder's **home address**: _____

**Medicare Patients Only-**
**Social Security Number**: _____

I, the undersigned, have insurance coverage with_____
and I assign payment of authorized healthcare benefits and any other medical and/or surgical benefits to which I am entitled directly to **Celina M. Nadelman, MD** and **Precision Aspiration & Biopsy** Laboratory, for any services furnished to me by the physician (Dr. Celina Nadelman). I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits or payment thereof. I authorize the use of this signature on all my insurance submissions.

_____ Date: _____
Name of the insured/guardian

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# Consent for Fine Needle Aspiration (FNA) and Biopsy and Privacy Practices

Celina Nadelman, M.D., Laboratory Director

1. An FNA/Core needle biopsy is a small needle biopsy inserted into the area in question, to remove tissue for diagnosis. The main risks of the procedure are pain, bleeding, bruising and extremely seldom, infection. Rarely, there is a risk of a non-diagnostic result.

2. I understand that while FNA/Core needle biopsy is a very good test, it is not a perfect test. There is a small probability, depending on the size, location and type of lump, that it may not be interpreted as cancer when cancer is there. And rarely, it may falsely be interpreted as cancer when cancer is not there. However, most doctors believe that FNA/core needle biopsy is a very good test.

3. After having been informed of the values, limitations, risks, complications and alternatives of this procedure, I hereby authorize and direct Dr. Celina Nadelman and associates to perform fine needle aspiration/core needle biopsy.

4. I have read the Privacy Practices Summary (HIPAA) posted on the wall of the office. I understand my rights to receive my health information and decide who else has access to receive it. By signing below, I acknowledge my receipt of this document.

_____ _____

Signature of Patient Printed Name of Patient

_____ _____

Signature of Witness Printed Name of Witness

_____ _____

Signature of Guardian Signature of Translator

_____

Date

**Celina M. Nadelman, M.D.**
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# INSURANCE AND PAYMENT ACKNOWLEDGEMENT

Date:_____ Patient's Name: _____

## INSURANCE ACKNOWLEDGMENT

Due to the new insurance plans that became available through Covered California in January 2014, we can no longer confirm that your policy is contracted with our office. We are not contracted with any Covered California insurance plans or plans independent of the exchanges that "mirror" Covered California plans. However, we will submit a claim for services rendered in our office to your insurance plan as a courtesy to you, our patient. Even though we may not participate in your insurance plan, it is usually possible to work out an acceptable financial arrangement.

Although we submit your claim to your insurance carrier, occasionally more than one site needs to be biopsied. Additional sites may not be covered by your insurance plan. Please note that certain codes may not be covered by your insurance plan. It will be your responsibility to pay for any codes that your insurance plan does not cover. Please make sure to accurately fill out all paperwork provided and give us the correct insurance information so that we may bill your insurance. If there are any errors on your part, you may incur a billing fee or may be responsible for the entire billed amount.

Although we make every effort to determine if your insurance plan covers our services, you will be responsible for any additional out of pocket expenses. It is the responsibility of you, the patient, to pay the co-pay or balance for services rendered, within a reasonable time. Please feel free to contact our office at (310) 702-6701 to discuss any questions or concerns you might have regarding your bill.

## 3RD PARTY FEES

Occasionally, additional studies are needed to be performed during your visit. Sometimes the FNA sample that was obtained may be sent to a reference laboratory (a specialized laboratory at an outside facility, not our laboratory, Precision Aspiration and Biopsy) for this additional testing. Please note that third party laboratories may require additional costs to you. The amount of these charges will be completely separate from those of Dr. Nadelman and Precision Aspiration and Biopsy's services and are unknown.

## CREDIT CARD AUTHORIZATION

With my signature below, I authorize Celina M. Nadelman, M.D., A Medical Corporation, Precision Aspiration and Biopsy, and its billing agents to make charges to my credit card for any remaining balance not billable/payable by my insurance carrier for services provided, or any remaining self-paying balance. An invoice will be sent via mail. As a courtesy, if your payment is not received within one month of the invoice sent, we will charge the credit card on file for outstanding balances.

**Patient Initials: _____**

**I have read and understand the above information.**

Patient's signature Printed Name Date

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In an effort to maintain continued quality care for you, our patient, a copy of your health record, including but not limited to, the final diagnostic interpretation (cytological and surgical pathology reports) from _____ institution is requested.

| PATIENT INFORMATION | OTHER INSTITUTION |
|---|---|
| Patient Name | Institution/Physician |
| Date of Birth | Street Address |
| Street Address (if needed) | Attention to: Room Number |
| City, State, Zip | City, State, Zip |
| Telephone | Telephone Number |
| | Contact Person |

**Materials Requested by Precision Aspiration and Biopsy:**

| Case Acct. # | Report Only | Blocks | Slides | Other/Diagnosis |
|---|---|---|---|---|
| | | | | |

**Re-disclosure:** I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996.
**Patients Rights:** I may refuse to sign this authorization and neither treatment, payment, enrollment, nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. I have a right to a copy of this authorization.
**California Law:** California law prohibits Precision Aspiration and Biopsy from making further disclosure of my health information unless Precision Aspiration and Biopsy obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

**Signature of Patient or Personal Representative Who May Request Disclosure**
I can inspect or copy the protected health information to be used or disclosed. I authorize Precision Aspiration and Biopsy and Dr. Celina M. Nadelman to have access to the protected health information specified above.

Signature: _____ Date: _____