Michelle Kolsi, MD
110 West Stocker Street
Glendale, CA 91202
Tel (818) 244-7237 Fax (818) 244-6787

PATIENT INFORMATION

Child's Name _____ Birth Date _____
Child's Name _____ Birth Date _____
Child's Name _____ Birth Date _____
Child's Name _____ Birth Date _____
Child's Name _____ Birth Date _____

Children reside with: Parents Mother Father Other _____

Father's/Parent/Partner Name _____ Birth Date _____
Home Address _____
City _____ State _____ ZIP _____ Home Phone #_____
E-mail _____ Cell Phone # _____
Social Security # _____ Work Phone # _____
Employer _____ Occupation _____

Mother's/Parent/Partner Name _____ Birth Date _____
Home Address _____
City _____ State _____ ZIP _____ Home Phone #_____
E-mail _____ Cell Phone # _____
Social Security # _____ Work Phone # _____
Employer _____ Occupation _____

Referred by:_____

Please provide a copy of your insurance card. **The above individual is responsible for all fees for services rendered** including collection costs in the event of default.
Signature _____ Date _____

Assignment of Benefits. I hereby assign to the physician all money to which I am entitled for medical expense relative to the services billed, but not to exceed my indebtedness to said physician. I also authorize the release of information needed to process medical claims.
Signature _____ Date_____

A **parent or guardian must be present** for all examinations and treatment. I authorize the following person(s) to bring my child (children) in for medical treatment:
Name _____ Relationship _____
Name _____ Relationship _____
Signature_____ Date _____

In the event that I am unavailable, I authorize Michelle Kolsi, M.D. or her authorized representative to **provide medical or surgical treatment in case of emergency.**
Signature_____ Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of the Patient Health Information privacy practices as required by the Health Insurance Portability and Accountability Act.
Signature_____ Date_____