FAY M. AZAD, M.D.
Adult & Adolescent Psychiatry
2535 Townsgate Rd., Suite 209
Westlake Village, CA 91361
Telephone (818) 889-8555

APPLICATION FOR TREATMENT

Patient Information

Patient's Name _____ Date _____

Sex _____ Birthdate _____ Soc. Sec. # _____

Single _____ Married _____ Divorced _____ Widowed _____

Legal Guardian (if a minor - under 18 years of age) _____

Street Address _____ City _____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____

Occupation _____ Employer _____

Employer Address _____ Work Phone _____

Driver's License Number _____ Exp. Date _____

Insurance Information (copy of cards required)

Copayments and Coinsurance Payments are due at the time of your visit.
No insurance: Payment is due in full at the time of your visit.

Primary Insurance _____ Member # _____

Insured's Name _____ Group # _____

Billing Address _____ City _____ Zip _____

Secondary Insurance _____ Member # _____

Billing Address _____ City _____ Zip _____

Authorization # _____

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE OFFICE POLICY. THE PATIENT OR LEGAL GUARDIAN IS RESPONSIBLE FOR PAYMENT ON THIS ACCOUNT. CANCELLATIONS MADE WITH LESS THAN 24 HOURS NOTICE AND APPOINTMENTS NOT ATTENDED WILL BE BILLED TO THE PATIENT AT THE FULL FEE. DELINQUENT ACCOUNTS ARE REFERRED TO COLLECTIONS AND THE PATIENT IS RESPONSIBLE FOR A $50 PROCESSING FEE IF ACCOUNT IS TURNED OVER TO COLLECTIONS.

I have read the above and agree to the terms of this office.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Date of Appointment