Olga Zarkh MD, 135 North Arlington Heights Rd, Suite 160 Buffalo Grove IL 60089

Phone: 847.818.7700   Email: info@yourpersonaldoctor.com

(*)Patient Name____
(*)Sex: Male   Female Third Gender :   (*)DOB:___/___/____

(*)Address____

(*)City____ (*)State:_____(*)Zip Code_____________________

(*)Mobile Phone # ____

Alternative Phones # ______________________________________

Mobile Phone Application You are using (for VIP or Telemedicine): WhatsUp, Signal, Telegram, Viber_____

(*)E-mail:____

Emergency Contact n mandatory ame___________________________________Relationship
____

Emergency Phone #_________________________

(*)Pharmacy Name:_____________________ Address____

(*)Pharmacy Phone # _________________________

Primary Insurance _________________________________Policy #_____________________________________
Group #___________________
Policy Holder Name________________________________Relationship to patient_________________________

Secondary Insurance (if any) ________________________ Policy #__________________Group #_____________

ASSIGNMENT AND RELEASE OF MEDICAL INFORMATION
I, the undersigned, have insurance coverage with ____and assign directly to Dr. Olga Zarkh all medical benefits, if any, otherwise payable to me for services rendered. 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 the payments of benefits. I authorize the use of this signature on all my insurance submissions.
INSURANCE AUTHORIZATION
I request that payment of authorized insurance benefits be made on my behalf to Dr. Olga Zarkh for any services provided for me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its representatives any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In the Insurance assigned cases, the physician or supplier agrees to accept charge determination of the Insurance carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Insurance carrier.

(*)Signature:____(*)Date______________________________

(*)Mandatory fields