DR. KAMRAN JAMSHIDINIA, DPM, FACFAS

Board Certified, American Board of Podiatric Surgery Fellow, American College of Foot & Ankle Surgeons

TOWER FOOT & ANKLE SURGERY

2080 Century Park East Suite 1208 Los Angeles 90067

Tel: (310) 247-9255 Fax: (310)247-9240

Web: www.LAfootdoc.com

We welcome you to our practice !

TODAY'S DATE__________________

PATIENT____
Last Name First Name Middle Name

MR___MRS___MS____DR____ MARITAL STATUS S M D DP W

MALE___ FEMALE ___ DOB________ AGE_____ SS# ______________________________

HOME ADDRESS ____

CITY/STATE/ZIP____

HOME PHONE #______________________WORK #_________________EMAIL: _____________________

CELL PHONE #____________________________ EMPLOYER NAME___________________________

OCCUPATION__________________________EMPLOYER PHONE___________________________

EMPLOYER ADDRESS____

SPOUSE NAME______________________________________DOB____________ PHONE#_________________________

IN CASE OF EMERGENCY WHO MAY WE CONTACT ?

NAME______________________________________RELATIONSHIP____E
MERGENCY PHONE NUMBERS
1.)____ 2.)____

PRIMARY CARE PHYSICIAN NAME____ PH#________________________

REFERRING PHYSICIAN NAME____ PH#________________________

HOW DID YOU HEAR ABOUT OUR PRACTICE? TV RADIO GOOGLE YAHOO MAGAZINE NEWSPAPER DOCTOR
IF REFERRED BY AN INDIVIDUAL WHO MAY WE THANK ______________________________________

PRIMARY INSURANCE COMPANY:_________________________PHONE#________________________________

CLAIMS ADDRESS____CITY______________________STATE_____ZIP________

SUBSCRIBER NAME_________________DOB_________RELATIONSHIP_____________________________________

POLICY ID #__________________________________ GROUP #____

PERSON RESPONSIBLE FOR PAYMENT____

ADDRESS____SS#_____________________________**S**
ECONDARY INSURANCE IF ANY:
INSURANCE COMPANY:____PHONE#________________________

CLAIMS ADDRESS_______________________________________ CITY STATE/ ZIP ________________________________

ZIP CODE _____________ SUBSCRIBER NAME____ DOB________________
RELATIONSHIP_______________________________ ID #____________________________ GROUP #_____________________

By signing below, I certify that the above is true and correct. I agree to notify the office of any changes to my insurance and/or address/phone numbers as soon as my information changes.

__X____ ______________________________________
Patient or Legal Guardian Signature Date

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TODAY'S DATE__________________

PATIENT____

Last Name First Name Middle Name

HEIGHT_______ WEIGHT_________ SHOE SIZE _______ AGE ______ OCCUPATION___________________DO YOU LIVE ALONE? ___________

Reason for visit:____

When did current problem(s) start ?____

Has condition worsened or improved ?____

What makes the condition better ? Worse ?____

Have you previously been treated for this condition ? If so how and by whom ?______________________________

Medical History:

Please list all prior **OPERATIONS**/Dates ?

List your **MEDICATIONS** including dosage and frequency:

Are you **ALLERGIC** to anything ? (include foods/adhesives/tape/dye) (Include any anesthesia related problems in you or your family)

Have you ever been **HOSPITALIZED** ? (include dates and reason for admission)

Do you have any **ILLNESSES** ?

Do you drink or smoke ? If so, how much ?

ILLNESSES IN YOUR **FAMILY**:

Mother:

Father:

Siblings:

Children:

REVIEW OF SYSTEMS

YES	NO	HEAD/EARS/EYES/NOSE/THROAT
		Any History of Trauma to your head, neck, or face ? Any motor vehicle accidents with whiplash ?
		Any ringing in your ears or hearing loss ? Any prior or current Ear Nose Throat problems ? Headaches/Migraines?
		Any blurry Vision, Double Vision, or problems with balance ? Glasses ? Contacts ?
		Any chronic sinus problems, septal deviation ? Any chronic allergies ? Any Asthma? Snoring problem/Sleep Apnea ?
		Any current dental cavities or infections ? When was your last dental check up ?
		Ever been told to take antibiotics before a dental procedure ? Any problems at the dental office with anesthetics used ?
		Any Thyroid, parathyroid problems ? Any history of psychiatric treatment? History of Depression ? Seizures/Epilepsy ?
		Any arthritis in your neck ? Any family history of arthritis (disfiguring type)?
		HEART & LUNGS
		Any history of Chest pain with exertion or activity ? Any history of chest pain with radiation to jaw ? Any prior heart attacks ?
		Any shortness of breath with activities ? Any shortness of breath with lying flat ? Any history of Stroke ?
		Any history of swelling in your legs or ankles ?
		Do you have or have you had HIGH BLOOD PRESSURE ? HIGH BLOOD CHOLESTROL ?
		Any history of Rheumatic Heart Disease ? Any history of irregular heart beat ? Murmur ? Atrial Fibriliation ? Palpitations?
		Do you have asthma/emphysema/ or other lung disease ?
		Any history of TB (tuberculosis) ? Chronic Cough ? Pneumonia ?
		Other Heart or Lung Problems: Please List : Articial Valves ?
		Do you use any illegal drugs ? Do you have a history of Coccaine use ? Do you abuse any over the counter or prescription drugs ?
		Do you have a history of abusing drugs or alcohol ? Page 2

YES	NO	ENDOCRINE
		Do you have diabetes or been told you are borderline diabetic ?
		Have you ever had pancreatitis ?
		Do you have high blood pressure ?
		Any unexplained weight loss or gain ?
		Any frequent urination ? Any frequent thirst ? Any frequent eating ?
		Any other endocrine problems ? Any history of gout ? Any hemophilia in you or a family member ? Any bleeding problems ?
		GENITAL URINARY/ GASTROINTESTINAL
		Any history of inability to pass uring ? Any urinary stones ? Any history of urological problems ? Prostate Problems (men) ?
		Any history of blood in your urine ? Any urinary incontinence ? Any history of impotency ?
		Any frequent urination or burning with urination ? Any history of STDs ? Any history of HIV or AIDS ?
		Any history of Genital Urinary Cancers ? Any history of gynecological problems ? History of kidney problems/infections ?
		Colon Cancer, Polyps, Chronic Diahrea or Constipation/ Blood in your stool/Black Tarry stools ? When was your last colonoscopy ?
		Liver disease or Hepatitis history? If so what type of Hepatitis ?
		EXTREMITIES
		Any coldness or color changes in your legs ? Any cramping in your calves with ambulation ? If so, how far can you walk ?
		Any limitations to exercise ? Any history of limping ? Any childhood foot/ankle braces or devices ?
		Any history of blood clots in your legs (DVT)?
		Any history or current use of Blood thinning medicine Coumadin ?
		Any tingling/pins and needles or feeling of feet being asleep ? Any low back pain ?
		Any radiating type of pain from your back down your legs ?
		Any injuries to your extremities ? Any other orthopedic problems? Hip/knee/ankle/elbow/shoulders/wrists/fingers?
		Any arthritis or rheumatoid arthritis (disfiguring type) in you or your family ? Artificial Joints/Implants?
		FOR DIABETICS ONLY: LAST FINGER STICK ? How often do you check ? What are your sugars avg ?
		Who is following you for your Diabetes ? What is your last HgA1C ? When was your last eye exam ?
		Ever been told you have neuropathy ? Hi risk for foot ulcers ? Prior foot ulcer history ?

We thank you for taking time to fill out this form as all questions relate to your DIAGNOSIS AND TREATMENT.

REVIEWED

Dr. Kamran Jamshidinia, DPM, FACFAS **Date** **Update**

By signing below I certify that the health questionnaire is true, complete, and accurately reflects my current health status and entire medical history. I Agree to notify this office if there are any changes to my medications/health problems.

_X____

Patient/ Patient Parent or Legal Guardian if Minor Date

TREATMENT CONSENT

I hereby consent and give my permission to Dr. Kamran Jamshidinia (or the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

X

Patient Signature (responsible party) **Date** **Witness** **Date**

Please print Name of Patient, Parent, Guardian or Representative **Relationship to Patient**

PHARMACY INFORMATION

Pharmacy Name: ____

Pharmacy Address:____

Pharmacy Phone Number:____

PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

X____ _______________________

Patient Name (or Legal Guardian) Printed Birthdate

X

Patient or Legal Guardian Signature Date

MESSAGES LEFT AT YOUR HOME/ANSWERING MACHINE

Due to the recent implementation of the Patient Privacy Act (HIPPA), it is necessary to obtain authorization for our office to leave messages at your home with family members and/or on answering machines/ voicemails regarding the following:
- Confirm or Change Appointment/ Discuss billing
- Results of testing ordered by the physician
- And/or any pertinent information that may be relative to your care

❏I AUTHORIZE Please use the following number for all my messages ____

❏I DO NOT AUTHORIZE

X____
Patient ***Signature (Parent, if patient is a minor)*** ***Date***

TOWER FOOT & ANKLE SURGERY FINANCIAL POLICY/AGREEMENT:

Thank you for choosing our practice for your foot and ankle care. The following is our financial agreement with you and we expect you to read and sign this agreement before seeing the doctor. FULL PAYMENT IS PAYABLE AT THE TIME OF SERVICE. We accept VISA, MASTERCARD, DISCOVERY, AMEX and CASH.

It is important that you as the patient understand, regardless of what type of claim or insurance you provide on this form, it is the patient's responsibility to pay all fees incurred not covered by insurance (private and/or work comp/medicare) or met by your attorney at time of settlement. By signing below, you agree to pay any and all balances not covered by your insurance company including services provided to you that are denied or uncovered benefits on your particular plan. You also agree to pay all copays, deductibles, coinsurances at the time services are rendered. In the event that an insurance check is sent directly to you, you agree to kindly endorse the insurance check and forward the check to our office immediately or simply bring it in to our office so that those funds can be applied immediately to your account. Failure to do so will result in liability of entire billed amount to your insurance.

Lastly, you agree to pay up front for any expensive frequently denied services including those related to surgery, durable medical goods and orthotic devices. I understand there is a no refund policy on medical services rendered and medical devices that have been dispensed to the patient including not limited to orthotics, cam walkers, canes and any and all other durable medical goods and medical services.

Insurance Policy:

We accept assignment on most insurance benefit plans. In the event you insurance company does not pay the assigned benefit within 60 days, the balance will then be your responsibility. Please note that some, and perhaps all of the services may be considered non-covered, or reasonable and necessary services under your plan, in that event, you will ultimately be held responsible for the fees. We will advise you of any non-covered services prior to treatment. However, you understand that in no way are we able to guarantee that all services will be covered benefits by your particular plan, and hence any benefits that are later found to be uncovered will be your responsibility. Thank you for understanding our financial policy. If at any time you have questions about treatment, fees or services, please feel free to discuss it with us promptly and openly.

In order to continue to provide excellent medical care to you and to keep costs down, there are no exceptions to this financial policy.

By signing below, I understand and agree to the office financial policy/agreement.

_X____ ________________ ____
Patient/ Patient Parent or Legal Guardian if Minor **Date** **Witness** **Date**

APPOINTMENT CANCELLATION POLICY:

TO ALL PATIENTS:

Our office is now requiring a 24 hour cancellation notice on all appointments. Failure to call and cancel your appointment within 24 hours prior to your appointment will result in a $25 missed appointment/no call fee.

X
Patient Signature or Parent/Legal Guardian **Date** **Witness** **Date**

SIGNATURE ON FILE:

1.) **I authorize the use of this form on all insurance claim submissions on my behalf;**
2.) **I authorize the release of all pertinent medical information to my insurance carrier to facilitate payment of medical claims submitted on my behalf;**
3.) **I also authorize release of my medical information to my referring physician(s), my primary care provider, and any and all physicians/healthcare providers and/or facilities that the doctor decides to refer my care to.**
4.) **I understand that, ultimately, I am responsible for all fees associated with my treatment, including any collections costs/collection agency costs, including any legal applicable interest and attorney fees to recoup my debt. I understand that there is a $50.00 returned check fee.**
5.) **I authorize Dr. Kamran Jamshidinia, or his associates, to act as my agent in obtaining fees for services rendered to me.**
6.) **I authorize the release of payment whether payable to me, Tower Foot & Ankle Surgery, Dr. K. Jamshidinia or his associates directly to Tower Foot & Ankle Surgery/Dr Kamran Jamshidinia.**
7.) **I authorize Tower Foot & Ankle Surgery, the office of Dr. Kamran Jamshidinia or its associates to use and copy this form in place of my original signature.**

8.) **I understand that any CO-PAYS and/or DEDUCTIBLES and/or COINSURANCES are due at the time of my appointment.**

9.) **I understand that I must provide all the necessary authorizations and/or referrals, should my plan require it, at the time of service. Furthermore, I understand that in no way I hold Dr. Kamran Jamshidinia/Tower Foot & Ankle Surgery responsible for any insurance verifications of coverage/preauthorizations. I understand that despite the fact that Tower Foot & Ankle Surgery/Dr. Kamran Jamshidinia and its associates will make their best efforts to accurately obtain my benefits in advanced, such verifications of coverage do not always guarantee payment by my insurance company. For this reason, I release Tower Foot & Ankle Surgery/ Dr. Kamran Jamshidinia and its associates for any wrong doing in any cases where coverage is denied by my insurance despite this office obtaining verbal confirmation of coverage by my insurance companies agents.**

10.) **I further understand that should I not provide valid referral and/or authoriziation, I will be responsible for the cost of the visit.**

X

Patient Signature (responsible party) **Date** **Witness** **Date**

INSURANCE ASSIGNMENT

Insurance Company Date ___________________________

To____

Group No. Certicate No____

I hereby authorize Dr. Kamran Jamshidinia, DPM/ Tower Foot & Ankle Surgery and its associates to release to your company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of Medical or surgical care.

I also authorize and request your company to pay directly to the above named doctor, the amount due me in my pending claim for medical or surgical treatment or services, by reason of such treatment of services rendered.

I understand that I am financially responsible for charges not covered by this authorization.

FINANCIAL RESPONSIBILITY

PATIENTS WITH INSURANCE

As a courtesy to patients with private health care insurance, we do complete and file claims with the appropriate insurance companies (provided all necessary information is obtained from you), however, all patients are kindly requested to understand that the financial responsibility for our services still remain theirs, the patient, and not their insurance companies. Even though an insurance claim is filed on the patient's behalf, this office cannot accept responsibility for collecting the claim nor can it get involved in negotiating settlement on a disputed claim. Payment of our fees is at all times the sole responsibility of the patient.

PATIENTS WITH MEDICARE

Dr. Kamran Jamshidinia, DPM/Tower Foot & Ankle Surgery & its associates accept Medicare assignment. In the event that Medicare checks are mailed directly to the patient, kindly endorse the back of the Medicare Check and send it to our office or simply bring it it. If you have insurance in addition to your Medicare, please send in the EXPLANATION OF MEDICARE BENEFITS (EOMB)-the portion attached to your medicare checks. Your secondary insurance company will not accept claims without the EOMB. Any portion of your bill not paid by Medicare is the responsibility of the patient.

ALL PATIENTS

I, the undersigned, do hereby assume full responsibility for the payment of services rendered to this patient. Furthermore, I assign my insurance benefits, in connection with all services rendered, to Kamran Jamshidinia, DPM/Tower Foot & Ankle Surgery and its associates. I understand that I shall be responsible for any service which is not covered in part or as a whole by insurance. I understand that office verifications of coverage for treatment or services in no way guarantees payment from my insurance company.

Should the account be referred to a professional collection agency for collection the undersigned shall pay reasonable attorney's fees and collection expenses. All deliquent accounts shall bear interest at the legal rate after 60 days.

The undersigned certifies that he/she has read the foregoing, and has received a copy thereof and furthermore attests that he/she is either the patient or an authorized representative of the patient to execute this form and accept its terms.

_X____ ____

Patient Signature **Date** **Patients Agent or Representative**

____ ____

Witness **Date** **Relationship to Patient**