

- Pedram Kahen, DPM** Diplomat, American Board of Foot and Ankle Surgery
- Pegah Panirian, DPM** Diplomat, American Board of Podiatric Medicine

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: DIABETES CANCER HEART DISEASE HIGH BLOOD PRESSURE
 STROKE CORONARY ARTERY DISEASE THYROID DISEASE RHEUMATOID ARTHRITIS
 OTHER _____

YOUR MEDICAL HISTORY

ALLERGIES: MEDICATIONS _____
 ANESTHESIA _____ FOODS _____
 TAPE LATEX SHELLFISH IODINE OTHER _____
 NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

ACID REFLUX	<input type="checkbox"/>	FIBROMYALGIA	<input type="checkbox"/>	NEUROPATHY	<input type="checkbox"/>
ANEMIA	<input type="checkbox"/>	GOUT	<input type="checkbox"/>	OPEN SORES	<input type="checkbox"/>
ARTHRITIS	<input type="checkbox"/>	HEART ATTACK	<input type="checkbox"/>	PNEUMONIA	<input type="checkbox"/>
ASTHMA	<input type="checkbox"/>	HEART DISEASE/FAILURE	<input type="checkbox"/>	POLIO	<input type="checkbox"/>
BACK TROUBLE	<input type="checkbox"/>	HEPATITIS	<input type="checkbox"/>	RHEUMATIC FEVER	<input type="checkbox"/>
BLADDER INFECTIONS	<input type="checkbox"/>	HIV+ /AIDS	<input type="checkbox"/>	SICKLE CELL DISEASE	<input type="checkbox"/>
ABNORMAL BLEEDING	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	SKIN DISORDER	<input type="checkbox"/>
BLOOD CLOTS	<input type="checkbox"/>	KIDNEY DISEASE	<input type="checkbox"/>	SLEEP APNEA	<input type="checkbox"/>
BLOOD TRANSFUSION	<input type="checkbox"/>	LIVER DISEASE	<input type="checkbox"/>	STOMACH ULCERS	<input type="checkbox"/>
BRONCHITIS/EMPHYSEMA	<input type="checkbox"/>	LOW BLOOD PRESSURE	<input type="checkbox"/>	STROKE	<input type="checkbox"/>
CANCER	<input type="checkbox"/>	MIGRAINE HEADACHES	<input type="checkbox"/>	THYROID DISEASE	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	MITRAL VALVE PROLAPSE	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>

OTHER CONDITIONS: _____

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

SIGNATURE OF PODIATRIC PHYSICIAN

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

SIGNATURE

DATE

714 N. Avalon Blvd. Wilmington, CA 90744
426 W. Manchester Blvd. Inglewood, CA 90301
(888) 535-3668 Fax: (888) 269-5439

Patient Initial: _____

- Pedram Kahen, DPM** Diplomate, American Board of Foot and Ankle Surgery
- Pegah Panirian, DPM** Diplomate, American Board of Podiatric Medicine

Notice of Privacy Practices Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practices notice of privacy practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practices legal duties with respect to my protected health information.

The notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required by law to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make to each of the following purposes:
Treatment, payment and healthcare operations.
- Description of uses and disclosures that will be made only with a written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and brief description of how I made exercises these rights in the relation to:
 - The right complaint this practice, medical Board of California and to the secretary of human health services if I believe my privacy rights have been violated, and no retaliatory actions will be used against me in the event of such complaints
 - The right to request restrictions on certain uses and disclosures of my protected health information and at this practice is not required to agree to a requested restriction.
 - The right to receive confidential communication of protected health information.
 - The right to inspect and copy protected health information.
 - The right to amend protected health information.
 - The right to receive an accounting of disclosures of protected health information.
 - The right to obtain a paper copy of the notice of privacy practices from this practice upon request

This practice reserves the right to change in terms of its notice of privacy practices and two making U. provisions effective for all protected health information that it maintains. I understand that I can obtain this practices / current notice of privacy practices upon request.

Patient's signature _____ Today's date _____

Relationship the patient (if signed by patient's representative) _____

714 N. Avalon Blvd. Wilmington, CA 90744
426 W. Manchester Blvd. Inglewood, CA 90301
(888) 535-3668 Fax: (888) 269-5439

Patient Initial: _____

- Pedram Kahen, DPM** Diplomate, American Board of Foot and Ankle Surgery
- Pegah Panirian, DPM** Diplomate, American Board of Podiatric Medicine

Financial Policy

Patient Name: _____

Date of Birth: _____

Thank you for choosing **Legacy Foot and Ankle Center** as your health care provider. We are committed to your treatment being successful. The following is a statement of our **Financial Policy** that we ask you to read, agreed to & sign prior to any treatment.

1. Payment is due at the time services are rendered, including copayment, deductibles and previous balances. We do bill insurance plans as a courtesy, but it is not a guarantee of payment. The accepts cash, checks, visa, MasterCard, American Express, and Discover.
2. It is your responsibility to verify with insurance plan/carrier prior to each appointments group and individual doctor is a participating provider. Please verify if any services such as office visits, orthotics, braces, injections, x-rays, surgeries and procedures require preauthorization. Some plans require preauthorization or referrals from the patient's family physician.
3. Written or verbal authorizations from insurance plans or management groups are not guaranteed of payment. All claims are reviewed by the insurance carriers after services are rendered and authorizations can be denied at the time of review. **Denied claims become the patient's responsibility.**
4. Statements are mailed after the insurance company has paid their portion. The count is then payable within 30 days. Overdue accounts are subject to \$15 fee. Accounts 90 days past due are subject to collection by an external agency, unless financial agreements are made with our office.
5. All supplies and products are dispensed which are not billable insurance must be paid for at the time they are dispensed.
6. Free parking is available in our parking lot. **Any parking fine is the patient's responsibility to pay.**
7. **There is a \$25 charge for any and all forms filled out by our office. Please allow 15 days for completion of forms.**
8. If for any reason you are more than 15 minutes late, we may have to reschedule the appointment.
9. If applicable, patients who fail to attend a scheduled appointment without providing advance notice may be subject to a \$75 no-show fee. This fee is not covered by insurance and is the patient's responsibility. The fee must be paid prior to scheduling future appointments, if applicable.
10. Repeated missed appointments may result in dismissal from the practice, in accordance with office policy and applicable laws.

I HAVE READ THE ABOVE AGREEMENT AND AGREE THE TERMS AND CONDITIONS AS SET FORTH BY LEGACY FOOT AND ANKLE CENTER.

Patient's signature _____

Today's date _____

Relationship the patient (if signed by patient's representative) _____

714 N. Avalon Blvd. Wilmington, CA 90744
 426 W. Manchester Blvd. Inglewood, CA 90301
 (888) 535-3668 Fax: (888) 269-5439

Patient Initial: _____