

Legacy Foot and Ankle Center

- ☐ **Pedram Kahen, DPM** Diplomate, American Board of Foot and Ankle Surgery
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PATIENT INFORMATION FORM (PLEASE PRINT)

DATE: ____/____/____ PATIENT NAME: _____, _____ DATE OF BIRTH: ____/____/____
LAST FIRST MI AGE: ____ SEX: M F

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

CELL PHONE #: _____ HOME PHONE #: _____

WORK PHONE #: _____ E-MAIL: _____

Do You Consent to Receiving Text, E-mail and Voice Messaging: ☐ Yes ☐ No

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

PRIMARY CARE DOCTOR: _____ PHONE: _____

PREFERRED PHARMACY: _____ PHONE: _____ ADDRESS: _____

EMPLOYER: _____ OCCUPATION: _____

(*FOR WORKER'S COMP ONLY*) SSN: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

INSURED NAME: _____ DATE OF BIRTH _____

SECONDARY INSURANCE: _____

MEDICATION LIST:

PLEASE LIST ALL PRIOR SURGERIES:

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

SOCIAL HISTORY

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE

☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT - HOW LONG AGO? _____ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT - HOW LONG AGO? _____ TYPE _____

☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

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

Patient Initial: _____

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

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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) _____

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Patient Initial: _____

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 catch, 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 _____

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Patient Initial: _____

Consent for Use of AI Medical Scribe

Patient Name: _____

Date of Birth: _____

Legacy Foot and Ankle Center uses **Commure Scribe**, a **HIPAA-compliant artificial intelligence (AI) medical scribe**, to assist your healthcare provider with documenting your medical visit. During your visit, the AI medical scribe may listen to and process the conversation between you and your healthcare provider in order to create a draft clinical note based on the information discussed during the visit.

The AI medical scribe is used as a **documentation tool** to assist your healthcare provider with preparing the clinical note for your medical record. The AI does not independently diagnose or make decisions regarding your medical condition or treatment. Your healthcare provider conducts your visit, reviews and, when appropriate, edits the documentation generated by the AI scribe, and remains responsible for your medical record, diagnosis, and treatment decisions.

VOLUNTARY PARTICIPATION

Your participation in the use of the AI medical scribe is **completely voluntary**. You may choose to participate or decline without providing a reason.

Choosing not to participate in the use of the AI medical scribe will **not affect the quality or level of care you receive, your treatment plan or medical recommendations, or your ability to receive healthcare services from Legacy Foot and Ankle Center.**

You may withdraw your consent at any time by informing your healthcare provider or office staff.

CONSENT

By selecting **“Yes,”** I acknowledge that I have read and understand the information above and voluntarily consent to the use of the AI medical scribe during my healthcare visit.

By selecting **“No,”** I understand that I am declining the use of the AI medical scribe and that doing so will not affect the quality of my care or my treatment plan.

☐ **YES, I CONSENT** to the use of the AI medical scribe during my healthcare visit.

☐ **NO, I DO NOT CONSENT** to the use of the AI medical scribe during my healthcare visit.

Patient's signature _____ Today's date _____

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

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Patient Initial: _____

AUTHORIZATION FOR PHOTOGRAPHY, VIDEO, AND MARKETING USE

Patient Name: _____

Date of Birth: _____

Legacy Foot and Ankle Center may photograph or video record patients for purposes of promoting and marketing our practice and services. Participation is completely voluntary and is not required to receive medical care from Legacy Foot and Ankle Center.

1. PURPOSE AND USE

By signing this authorization, I voluntarily authorize Legacy Foot and Ankle Center to photograph and/or video record me and to use my photograph, video image, likeness, and/or voice for the purpose of promoting and marketing the practice and its healthcare services.

Authorized uses may include, but are not limited to:

- The Legacy Foot and Ankle Center website;
- Social media accounts operated by Legacy Foot and Ankle Center;
- Brochures, flyers, newsletters, and other printed materials;
- Digital advertisements and promotional materials;
- Educational or promotional presentations; and
- Other marketing or promotional materials produced or distributed by Legacy Foot and Ankle Center.

If my photograph, video, or recording includes information relating to my medical condition, treatment, diagnosis, or healthcare services, I understand that such information may also be used in connection with the authorized marketing purposes described above.

2. VOLUNTARY PARTICIPATION

My participation in photography or video recording for marketing purposes is completely voluntary. I may decline to be photographed or recorded without providing a reason.

Choosing not to participate will not affect the quality or level of care I receive, my treatment plan or medical recommendations, or my ability to receive healthcare services from Legacy Foot and Ankle Center.

3. NO COMPENSATION

I understand that I will not receive compensation for the authorized use of my photograph, video, likeness, or voice unless otherwise agreed to in writing.

4. PUBLIC USE

I understand that materials used for marketing may be publicly available, including on websites, social media platforms, and other publicly accessible media. Once materials have been published or distributed, they may be viewed, copied, shared, or redistributed by others, and Legacy Foot and Ankle Center may not be able to control or retrieve copies that have already been distributed.

5. RIGHT TO REVOKE

I understand that I have the right to revoke this authorization in writing at any time by contacting:

Legacy Foot and Ankle Center - Phone: (888) 535-3668 - Email: legacyfootankle@gmail.com

I understand that revocation will not affect any action already taken in reliance on this authorization before my written revocation is received.

ACKNOWLEDGMENT AND AUTHORIZATION

I have read and understand this authorization. I have had the opportunity to ask questions regarding the use of my photograph, video, likeness, and/or voice. I voluntarily authorize the uses described above.

☐ **YES, I AUTHORIZE the photography and/or video recording and the use described above.**

☐ **NO, I DO NOT AUTHORIZE photography and/or video recording for marketing purposes.**

Patient's signature _____ Today's date _____

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