TOWER PODIATRY
THE FOOT & ANKLE SURGICAL INSTITUTE

PATIENT INFORMATION			
First Name:	Middle Name:	Last Name:	
Social Sec.#:	Date of Birth: / /	Age:	Sex: M F
Home Address:			
City:	State:	Zip Code:	Email:
Home Phone: ( )	Cell Phone: ( )	Work Phone :( )	
Preferred Method of Written Communication (Please circle one): Email Mail Fax: ( )			
(Please provide mailing address if different from above):			
Preferred Method of Verbal Communication (Please circle one): Home Phone Work Phone Cell Phone		May we leave a message? Yes No	
Race: (optional)	Ethnicity: (optional)	Marital Status: S M D W	Driver License #:
Occupation:	Employer:		
Employer Address:			
Primary Physician:	Phone: ( )		
Referred by:			

IN CASE OF EMERGENCY CONTACT	
Last Name:	First Name:
Relationship:	Phone :( )

PREFFERED PHARMACY			
Name of Pharmacy:	Phone: ( )		
Address(or cross streets):	City:	State:	Zip Code:

INSURANCE INFORMATION		
Name of Insured:	DOB: / /	Relationship:
Primary Insurance:	Phone: ( )	
Subscriber #:	Group #:	

I the undersigned, authorize DR_____ to examine and treat my feet medically, surgically, or biomechanically. I hereby assign my insurance benefits to be paid directly to TOWER PODIATRY and I am responsible for any unpaid balance. I authorize the release of any medical information necessary to process all claims.

SIGNATURE: _____ DATE: _____

GRARDIAN'S SIGNATURE: _____ RELATION: _____

IF PATIENT IS A MINOR (UNDER 18) OR UNABLE TO SIGN OWN CONSENT

OFFICE USE ONLY:
Chart #:_____ Provider:_____
REV 5/12

Name: _____ **Chart #:** _____

MEDICAL HISTORY

WHAT BROUGHT YOU TO SEE THE DOCTOR? (Please provide a brief description of the nature of the illness / injury.)

WHEN DID YOUR SYMPTOMPS BEGIN?

WHAT TREATMENTS HAVE YOU TRIED?

WHAT OTHER FOOT/ANKLE/LEG PROBLEMS DO/DIDYOU HAVE?

ALLERGIES: Do you have any allergies?	1.	2.	3.

MEDICATIONS: What medications are you currently taking?

1.	6.	11.	16.
2.	7.	12.	17.
3.	8.	13.	18.
4.	9.	14.	19.
5.	10.	15.	20.

PAST MEDICAL HISTORY

Please indicate whether you have had any of the following medical problems:

	Yes	No		Yes	No
Heart Disease			Arthritis		
Heart Valve Replacement			Gout		
Heart Attack			Fibromyalgia		
Chest Pain			Osteoporosis		
Pacemaker			Leg Pain		
High Blood Pressure			Back Pain		
High Cholesterol			Weakness In Extremities		
Stroke			Numbness In Extremities		
Shortness Of Breath			Balance Problems		
Lung Disease			Dizziness		
Asthma			Headaches/Migraines		
Sleep Apnea			Changes/Loss Of Vision		
Liver Disease			Stomach Ulcer		
Hepatitis			Tuberculosis		
Bleeding Disorder			HIV		
Clotting Disorder			Cancer *(What Type?)*		
Anemia			Thyroid Condition		
DVT (Blood Clot)			Pregnant		
Kidney Disease			Diabetes Type I __Type II __		
Fractures *(When/Where?)*					
Joint Replacement *(Which?)*			Skin Conditions *(What Kind?)*		
Other(S): *(Please specify)*					

FAMILY HISTORY

Please check if any of your family members have / had any of the following:

	Yes	No		Yes	No
Bleeding Disorder			Gout		
Cancer			Arthritis		
Heart Trouble			Bunion		
High Cholesterol			Bunionette		
High Blood Pressure			Flat Feet		
Stroke			High Arched Feet		
Diabetes			Pigeon-Feet		
Other*(Please specify):*					

SOCIAL HISTORY

	Yes	No	what kind,how much, & how often?
Do you smoke?			
Did you ever smoke?			
Caffeine? *(tea /coffee)*			
Alcohol use? *(Currently using or used in the past)*			
Illicit drug use?			
Do you exercise regularly?			

PAST SURGICAL HISTORY

Procedure	**Date**	**Surgeon**	**Complication**
1.			
2.			
3.			
4.			

HEIGHT: _____ **WEIGHT:** _____ **SHOE SIZE:** _____

I certify that to the best of my knowledge that the information provided is true and accurate and I have disclosed all pertinent medical history.

SIGNATURE OF PATIENT(OR GUARDIAN): _____ DATE: _____

TOWER PODIATRY
THE FOOT & ANKLE SURGICAL INSTITUTE

Arash R. Hassid, DPM, AACFAS B. David Massaband, DPM, FACFAS Albemar Espiritu, DPM

Patient Name: _____ Chart #: _____

FINANCIAL POLICY

Thank You for choosing Tower Podiatry 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, agree to and sign prior to any treatment.

1. **Payment is due at the time services are rendered, including co-payment, deductibles and previous balances.** We do bill insurance plans as a courtesy, but it is not a guarantee of payment. We accept cash, check, Visa, Mastercard and Discover.

2. **It is your responsibility to verify with insurance plan/carrier prior to each appointment that our group and the individual doctor is a participating provider.** Please verify if any services such as office visits, x-rays, and procedures require pre-authorization. Some plans require pre-authorization or referrals from the patient's family physician.

3. **Written or verbal authorizations from insurance plans or management groups are not a guarantee 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 account is then payable within 30 days. **Overdue accounts are subject to a $15 fee.** Accounts 90 days in arrears will be subject to collection by an external agency unless financial arrangements are made with our office.

5. All supplies and products dispensed which are not billable to insurance must be paid for at the time they are dispensed.

6. We recommend you verify with your insurance carrier whenever our office refers you to outside laboratories, hospitals, physical therapy or tests to insure that you do not require any pre-authorization.

7. **Parking:** If you choose to park in the building, No validation will be provided.

8. There is a **$25.00** charge for any and all forms filled by our office. Please allow 15 days for completion of forms.

9. We understand that some appointments cannot be kept due to unforseen circumstances. However, we ask for a 24-hour notice so that time can be rescheduled for another client. Our policy is to charge **$50.00** for an appointment that is cancelled with less than 24-hours notice.

10. If for any reason you are more than 15 minutes late, we may have to reschedule your appointment.

I HAVE READ THE ABOVE AGREEMENT AND AGREE TO THE TERMS AND CONDITIONS AS SET FORTH BY THE PRESTIGE FOOT AND ANKLE CENTERS.

_____
Patient or Patient's Representaive Signature

_____ _____
Relationship to patient (if signed by patient's Representative) Date

CEDARS-SINAI MEDICAL TOWER
8631 W. 3RD ST. SUITE 940-E
LOS ANGELES, CA 90048
TEL: (310) 657-2828
FAX: (310) 657-9733

ENCINO MEDICAL OFFICE
16661 VENTURA BLVD. SUITE 705
ENCINO, CA 91436
TEL: (818) 789-7891
FAX: (310) 657-9733

Your Rights Regarding Your Health Information

1. *Communications.* You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of you health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care, such as family members and friends. We are not required to agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to *Tower Podiatry*.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted *Tower Podiatry*. You must provide us with a reason that supports your request for amendment.

5. You have the right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front office receptionist.

6. You have the right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, *Tower Podiatry*. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. You have the right to provide an authorization for other uses and disclosures. Our practice will obtain written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

8. Any pictures taken from me at *Tower Podiatry* will solely be used for purposes of electronic medical chart keeping and will not be shared with any marketing and/or advertising agency, unless requested by any federal or state governmental agency.

If you have any questions regarding this notice or our health information privacy policies, please contact *Tower Podiatry*.

I hereby acknowledge that I have been presented with a copy of *Tower Podiatry's* Notice of Privacy practices.

SIGNATURE: _____ DATE: _____

PRINT NAME OF PATIENT: _____