VALLEY FOOT & ANKLE CENTER

PATIENT INFORMATION SHEET

Date: _____ □ New Patient □ Change of Information Patient no:_____

□ Would you like to receive email/Newsletter from us? Email:_____

How did you hear about us? □ Internet □ Doctor_____ □ Newspaper □ Family/Friend

PERSONAL INFORMATION:

Patient's Name: First_____ M.I._____ Last_____

Address_____

City_____ State_____ Zip_____

Sex: □ Male □ Female Employed: □ Yes □ No Employer/School #: _____-_____-_____

Phone: Home (_____)_____-_____ Work: (_____)_____-_____

Date of Birth: _____ Social Security #: _____-_____-_____

HEALTH PLAN INFORMATION: Pharmacy Name and location_____

No. of Health Plans: □ One □ Two □ Three

Name of Health Plan_____

Insurance ID #_____ Group No. _____

Relationship to Insured: □ Self □ Wife □ Husband □ Child □ Parent □ Other_____

IF INSURED IS OTHER THAN PATIENT PLEASE COMPLETE THE FOLLOWING:

Insured's Name _____ Social Security #: _____-_____-_____

Sex: □ Male □ Female Date of Birth: _____

Address_____

Employer_____

I hereby consent that Valley Foot & Ankle Center provide me with all the health care services that , at his discretion, is necessary for my treatment, I hereby authorize Valley Foot & Ankle Center the release of any medical or other information necessary to the health plans, government agencies, attorneys, or their representative for processing the claims.
I hereby authorize the health plans, government agencies, and attorneys to pay Valley Foot & Ankle Center the medical & surgical benefits allowable as payment towards the total charges for medical treatment, which is not covered by this assignment, and pay them promptly.
I understand that if for any reason my account is overdue more than 60 days, I pay interest at the rate of 12% per annual (1% per month) on all account balances. Further, I understand that if my account is assigned to any collection agency, there is a (25%) collection charge above and over the medical charges.
I am aware that upon using my health plan benefits for any services rendered by any out of network provider, I will be going out of network and exercising my "OPTOUT BENEFITS" choice.
I acknowledge that I have read this form and understand it's contents.

Patient's Signature_____ Today's Date_____

DR. JONES HORMOZI

Valley Foot & Ankle Center

16952 Ventura Boulevard Suite #100. Encino, CA. 91316

Office: (818) 981-1900 Fax: (866) 254-5997

Name:_____ Date:_____

MEDICAL HISTORY

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

WHEN DID YOUR SYMPTOMS BEGIN?

WHAT TREATMENTS HAVE YOU TIRED?

ALLERGIES: DO YOU HAVE ANY ALLERGIES?	1	2	3

MEDICATIONS: WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

1	6	11	16	21
2	7	12	17	22
3	8	13	18	23
4	9	14	19	24
5	10	15	20	25

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		
Fractures *(When/Where?)*			I____ Type II____		
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(s): *(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?			

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.

PAST SURGICAL HISTORY

PROCEDURE	DATE	SURGEON	COMPLICATION
1			
2			
3			
4			

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

DR. JONES HORMOZI
VALLEY FOOT & ANKLE CENTER
16952 VENTURA BOULEVARD SUITE #100
ENCINO, CA 91316
(818) 981-1900

Patient name:_____ Date of Birth:_____

FINANCIAL POLICY

Thank you for choosing Valley Foot & Ankle Center as your health care provider. We are committed to your eatment being successful. The following is a statement of our Financial Policy that we ask you to read, agree to and sign rior 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, orthotics, braces, injections, x-rays, surgeries and procedures require pre-authorization. Some plans require pre-authorization or referrals from the patients 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 patients responsibility.
4. Statements are mailed after the insurance company has payed their portion. The account is then payable within 30 days. Overdue accounts are subject to $15 fee. Accounts 90 days in arrears 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 to insurance must be payed for at the time they are dispensed.
6. Parking: is FREE beyond our building in our parking lot, street parking with parking meters are also available but it the patients responsibility to pay the meter and to keep track of the meter time. Also avoid street parking during street cleaning hours. Any parking fine is the patients 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 then 15 minutes late, we may have to reschedule your appointment.

HAVE READ THE ABOVE AGREEMENT AND AGREE TO THE TERMS AND CONDITIONS AS SET FORTH BY 'ALLEY FOOT & ANKLE CENTER.

_____
Patient or Patient's Representative Signature

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

DR. JONES HORMOZI
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NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT

Patient name:_____ Date of Birth:_____

I have received this practices notice of privacy practices written in a plain language. The notice provides in detail the uses and disclosures of my protect health information that may be made by this practice, my individual rights and the practices legal duties with respect to my protect 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 my written authorization and that I may revoke such authorization.
- My individual rights with respect to protect health information and a brief description of how I made exercises these rights in relation to :

    - The right to complain to this practice 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 a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that 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 protect health information.
    - The right to amend protect 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 the terms of its notice of privacy practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practices current notice of privacy practices on request.

Patient's Signature_____ Today's Date_____

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