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. B. DAVID MASSABAND DPM , DR. ARASH R. HASSID DPM, and or DR. PEGAH SAMOUHI 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: _____

GUARDIAN'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 #:**_____

WHAT IS THE REASON FOR YOUR VISIT, AND WHEN DID YOUR SYMPTON (S) BEGIN?

WHAT TREATMENTS HAVE YOU TRIED?

PREVIOUS FOOT, ANKLE, OR LEG PROBLEMS?

ALLERGIES

1.	**2.**	**3.**
4.	**5.**	**6.**

CURRENT MEDICATIONS

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

SOCIAL HISTORY

	Yes (How much & how often?)	No
Do you smoke?		
Did you ever smoke?		
Do you drink caffeine? (*tea/coffee/soda*)		
Do you exercise regularly?		
Alcohol use? (*currently or in the past)*		
Illicit drug use?		

FAMILY HISTORY

	Yes	No
Cancer		
Diabetes		
Heart Disease		
Foot and Ankle Problems (Flat feet, High arches, Bunions)		

MEDICAL HISTORY

Please indicate whether you have any of the following medical conditions.

	Yes	No		Yes	No		Yes	No
Anemia			Heart Attack			Fracture (*If yes, when/where?)*		
Arthritis			Pacemaker					
Asthma			High Blood Pressure			Joint Replacement (*If yes, when/where?)*		
Bleeding Disorder			High Cholesterol					
Cancer (*If yes, what type?)*			HIV			Skin Condition (*If yes, what type?)*		
			Kidney Disease			Back Pain		
Clotting Disorder			Liver Disease			Balance Problems		
COPD			Lung Disease			Changes/Loss of Vision		
Diabetes (Type I ___Type II ___)			Osteoporosis			Dizziness		
			Currently Pregnant			Headaches/Migraines		
DVT (Blood Clot)			Sleep Apnea			Leg Pain		
Fibromyalgia			Stomach Ulcer			Numbness in Extremities		
Gout			Stroke (CVA)			Weakness in Extremities		
Heart Disease			Thyroid Condition			Shortness of Breath		
Hepatitis			Tuberculosis			Other(s):		

SURGICAL HISTORY

Procedure	Date	Procedure	Date
1.		**4.**	
2.		**5.**	
3.		**6.**	

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

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

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

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. 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: _____CHART#:_____

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B. David Massaband, DPM, FACFAS | Arash R. Hassid, DPM, FACFAS | Pegah Samouhi, 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 which we ask you to read, agree, and sign prior to the performances of any services.

1. **Payment is due at the time services are rendered; including co-payment, deductibles, deposits, and previous balances.** We do bill insurance plans as a courtesy, but this is not a guarantee of payment. We accept payment in the form of cash, check (payable to B. David Massaband), and credit card (Visa, Mastercard, and Discover). There is a $10 minimum for any credit card transactions.

2. **It is your responsibility to verify with your insurance plan/carrier prior to each appointment that our group and the individual doctor treating you 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 $35 fee.** Accounts 90 days in arrears will be subject to collection by an external agency unless financial arrangements are made with our office. As a courtesy, payment plans are offered if needed.

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 ensure that you do not require any pre-authorization.

7. **Parking:** If you choose to park in the building, validation will not be provided.

8. There is a **$25.00 minimum** charge for any medical records requested from our office. Please allow fifteen days for completion of forms. There is also a **$10 minimum** charge for lab and/or imaging copies.

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 patient. The office policy is to charge **$50.00** for an appointment that is cancelled with less than a 24-hour 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 TOWER PODIATRY.

_____ _____
Patient or Patient's Representative Signature Date

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