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, DR. PEGAH SAMOUHI, and/or DR CARRILLO-KASHANI to examine and treat my feet medically, surgically, and/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. I also authorize electronic retrieval of my medications, imaging, x-rays, and medical records.

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 SYMPTOM (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:** _____

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B. David Massaband, DPM, FACFAS | Pegah Samouhi, DPM | Alexander Carrillo-Kashani, DPM

Patient Name: _____ Chart #: _____

FINANCIAL POLICY

Thank you for choosing the doctors at Tower Podiatry as your health care provider(s). 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 performance of any services.

1. **Payment: Payment is due at the time of service; including but not limited to co-pays, deductibles, deposits, and any outstanding balances.** Insurance will be billed, however, this is not a guarantee of payment. We accept payment in the form of cash, check (payable to B. David Massaband, DPM, Inc.), debit and credit card (Visa, Mastercard, and American Express), and Apple/Google Pay. Credit card transactions have a 3% surcharge and require a $10 minimum.

2. **Insurance Verification: Patients are responsible for confirming before each visit that both the practice and treating doctor are in-network and that their insurance is active.**

3. **Authorizations:** Insurance authorizations do not guarantee payment. If an insurer later denies a claim, the patient is responsible for the charges.

4. **Billing and Collections:** After insurane processes the claim, any remaining balance is due within 30 days of receipt of statement. Accounts may incur a $50 late fee for overdue balances. Accounts that are 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. **Supplies and products:** All supplies and products dispensed over the counter must be paid for at the time they are dispensed. They are non-refundable.

6. **Outside Services:** Patient's should verify with their insurance carrier whether referrals (such as labs, hospitals, physical therapy, or diagnostic tests) require authorization.

7. **Parking:** Parking validation is **not provided**.

8. **Forms and Medical Records**: There is a **minimum $25 fee** for medical records, work notes, disability forms, and other paperwork requested by the patient. Completion may take up to 15 days.

9. **Cancellation Policy:** Appointments canceled or missed with **less than a 24 hour notice** are subject to a **$100 fee**.

10. **Late Arrival Policy:** There is a 15 minute grace period. Arriving more than 15 minutes late may result in your appointment being cancelled or rescheduled.

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

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

UCLA HEALTH CENTER
4560 ADMIRALTY WAY SUITE 351
MARINA DEL REY, CA 90292
TEL: (310) 822-3572
FAX: (310) 657-9733

Privacy Rights Regarding Medical Information

1. **Communication Preferences:** You can ask the office to contact you in a specific manner or at a specific location (for example, call your cell phone instead of home). We will accommodate reasonable requests.

2. **Requesting Limits on Sharing:** You can ask the practice to limit how your health information is used or shared for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict information only to be shared with certain people involved in your care, such as family members. The practice is not required to agree to these restrictions, but if we do, we are bound by our agreement except in certain situations (such as emergencies or when required by law).

3. **Access Your Records:** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to *Tower Podiatry*. Medical Records requests are subject to a fee noted on the following page.

4. **Amendments:** If you believe your records are inaccurate or incomplete, you can request an amendment. Your request must be made in writing and submitted to *Tower Podiatry*. You must provide us with a reason that supports your request for amendment.

5. **Copy of Privacy 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. **Privacy Complaint:** If you believe your privacy rights have been violated, you can file a written complaint with the practice or with the U.S. Department of Health and Human Services. You cannot be penalized for filing a complaint.

7. **Authorization for Other Uses:** 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. **Clinical Photographs and Videos:** Any pictures taken from our office at *Tower Podiatry* will solely be used for your electronic medical record 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#: _____