HARBOR FOOT & ANKLE CLINIC
BIJAN SHEIKHIZADEH, D.P.M.
HARBOR MEDICAL BUILDING
1220 BASICH BLVD STE# C
ABERDEEN, WA 98520

Welcome to our office and thank you for choosing Dr. Sheikhizadeh for your foot care needs. We are a scent free facility and ask that you please be mindful of how strong your perfumes, lotions, cologne, and smoke smells are. If you check-in and are heavily scented, you may be asked to reschedule and incur a late reschedule fee.

Please fill out the enclosed paperwork using clear, legible handwriting. Bring these papers and your **current insurance card(s)** to your appointment. Please note that if your paperwork is not filled out before your check-in time noted below, it will result in rescheduling your appointment and in a fee of $50.
FAILURE TO CHECK-IN FOR YOUR SCHEDULED APPOINTMENT WILL RESULT IN A $50 CHARGE. Please note that if your paperwork is not filled out ***before*** your check-in time noted below you will be rescheduled. Thank you for your consideration. If you have any questions, please call 1-866-525-FOOT or 1-360-533-7388 for assistance.

Thank you,
Dr. Sheikhizadeh's staff

Please use **HEAVY ink.
Thank you

Appointment Date: _____

Check-In Time*: _____**am/pm**

***PLEASE NOTE: THIS IS YOUR CHECK-IN TIME, NOT YOUR APPOINTMENT TIME.**
****PLEASE NOTE: WHEN OUR AUTOMATED SYSTEM CALLS YOU, IT WILL TELL YOU YOUR APPOINTMENT TIME AND YOUR CHECK-IN TIME. AS A REMINDER YOUR CHECK-IN TIME IS NOTED ABOVE.***

HEALTH HISTORY

Patient Name _____ **Date** _____

Family Physician _____ **Phone** _____ **Pharmacy** _____

Chief Complaint: _____

History of present illness:

Location _____
(Where is the pain/problem?)

Duration _____
(How long have you had this pain/problem? When did it start?)

Severity _____
(How severe is the pain/problem?)

Modifying factors _____

(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

Have you ever had the following: (Please mark all that apply, leave blank if uncertain)?

( ) Smallpox	( ) Tuberculosis	( ) Hives or Eczema	( ) Thyroid Disease
( ) Pneumonia	( ) Diabetes	( ) AIDS or HIV+	( ) Bleeding Tendency
( ) Rheumatic Fever	( ) Cancer	( ) Mitral Valve Prolapse	( )Psoriasis
( ) Heart Disease	( ) Polio	( ) Stroke	( ) Crohns
( ) Arthritis	( ) Back trouble	( ) Hepatitis	( ) SLE
( ) Sexually Trans. Disease	( ) High Blood Pressure	( ) Ulcer	( ) Radiculopathy
( ) Epilepsy	( ) Asthma	( ) Kidney Disease	( ) Gout

Previous Hospitalizations/Surgeries/Serious Illnesses	**When?**	**Hospital, City, State**

All Medications

_____

_____

_____

Patient social history:

Use of alcohol: Never _____ Rarely _____ Moderate _____ Daily _____

Use of tobacco: Never _____ Previously, but quit _____ Current packs/days _____

Use of drugs: Never _____ Type/Frequency _____

Family medical history:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____

Review of Systems: Please indicate any personal history below:

Constitutional Symptoms
( ) Good General Health lately
( ) Recent weight change

Eyes
( ) Eye disease or injury

Ears/Nose/Mouth/Throat
( ) Nose bleeds
( ) Mouth sores
( ) Bleeding gums
( ) Swollen glands in neck

Cardiovascular
( ) Heart trouble
( ) Chest pain or angina pectoris
( ) Palpitation
( ) Swelling of feet, ankle, or hands
( ) Shortness of breath w/walking or lying flat

Respiratory
( ) Spitting up blood
( ) Shortness of breath

Gastrointestinal
( ) Change in bowel movements
( ) Nausea or vomiting

Genitourinary
( ) Blood in urine

Musculoskeletal
( ) Joint pain
( ) Joint stiffness or swelling
( ) Weakness of muscles or joints
( ) Muscle pain or cramps
( ) Back pain
( ) Cold extremities
( ) Difficulty in walking

Integumentary
( ) Rash or itching
( ) Change in hair or nails

Neurological
( ) Convulsions or seizures
( ) Numbness or tingling sensations
( ) Tremors
( ) Paralysis
( ) Head injury

Psychiatric
( ) Memory loss or confusion

Endocrine
( ) Glandular or hormone problem
( ) Excessive thirst or urination
( ) Heat or cold intolerance
( ) Skin becoming drier
( ) Change in hat or glove size

Hematologic/Lymphatic
( ) Slow to heal after cuts
( ) Bleeding or bruising tendency
( ) Anemia
( ) Phlebitis

Allergic/Immunologic
History of skin reaction or other adverse reaction to:
( ) Antibiotics_____
( ) Morphine
( ) Codeine
( ) Demerol
( ) Other narcotics
( ) Novocain/other anesthetics
( ) Aspirin/other pain remedies
( ) Iodine/Merthiolate
( ) Other antiseptic
( ) Sulfa
( ) Other drugs/medications:
_____
_____
_____

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____
Signature Date

_____ _____
Signature of Doctor Date

Personal Information

Name_____ Date of Birth ____/____/_____

Sex _____ Race_____ Married ___ Single ___ Widowed ___ Divorced/Separated ___

Home Address_____

City_____ State_____ Zip_____ Social Security No. _____

Primary Phone No. _____ Work Phone No. _____

Email Address _____

Occupation_____ Employer _____

Employers Address _____Phone No. _____

Emergency Contact _____ Relationship_____ Phone _____

(If patient is a minor or dependent adult, please give name of responsible party for finances and billing)

Responsible Party _____Date of Birth ____/____/____

Employer_____ Employers Phone number_____

Employers Address _____

Insurance Information (This must be filled in by you)

( ) Check here if **NO** health insurance Primary Carrier _____

I.D. Number _____ Group Number _____

Policy Holders Name _____

Date of Birth ____/____/_____ Social Security No._____

Secondary Carrier_____ I.D. Number _____

Group Number _____ Policy Holders Name _____

Date of Birth___/___/_____ Were you referred to our office? By whom? _____

Is this a compensation or work-related case? Yes ____ No____ Date of Accident _____

Briefly describe foot problem: _____

I hereby give the above-named doctor permission to administer the necessary treatment to diagnose and treat my present foot condition, after it has been explained to me.

Signature _____ **Date**_____

Relationship to patient _____

HARBOR FOOT & ANKLE CLINIC

SUMMARY OF NOTICE OF PRIVACY PRACTICES

(This summary is designed to assist you in understanding our Notice of Privacy Practices)

Health Information Use and Disclosure

The office of Dr Bijan Scheikhizadeh, DPM understands that medical information about you and your health is personal, and we are committed to protecting that information. With that understanding, we will use and disclose your health information for the following purposes: to treat you, to assist other healthcare providers in treating you, to allow insurance companies to process insurance claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operational activities, such as quality assessments, licensing, accreditations, and training of students. Except as stated in more detail in the Notice of Privacy Practices we will not use or disclose your health information without your written authorization. We reserve the right to change this notice and will post a copy of the current (dated) notices in effect in our facility.

Patients' Rights

As our patient, you have the following rights:

- To have access to inspect and /or obtain a copy of your health information that may be used to make decisions about your care.
- To receive an accounting of certain health information disclosures we have made regarding treatment, payment, or healthcare operations.
- To request that we communicate with you in confidence, in a certain way or at certain location. For example, you can ask that we only contact you by mail or at work.
- To request that we amend your health information if you feel medical information, we have about you is incorrect in incomplete.

To receive notice of our privacy practices by requesting a paper copy at any time.
If you have any questions, concerns, or complaints regarding our privacy practices, please refer to the actual Notice of Privacy Practices for the person(s) whom you may contact.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Patient Name or Authorized Representative Name (PRINT)

HARBOR FOOT & ANKLE CLINIC

Dr.BIJAN SHEIKHIZADEH, D.P.M.
1220 BASICH BLVD STE C
ABERDEEN, WA 98520

AUTHORIZTION OF MEDICAL INFORMATION

Patient Name_____ Date of Birth___/___/____

I authorize the personnel of Dr. Bijan Sheikhizadeh to release and discuss all medical & billing information to my family members and/or friends listed below.

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER

1_____

2_____

3_____

4_____

5_____

The release of information is valid from _____ until _____.

This release of information is not automatically renewable, it expires automatically at the end of the period specified unless revoked in writing sooner.

I understand I have the right to see this information.

I understand I can revoke this consent in writing to both the person (s) giving and the person (s) receiving the information. Any information already released may be used as stated on the consent form. By my signature below, I affirm that I have read this release of information, or it has been read to me, and I understand its content.

Permission to leave a message on a answering machine or voice mail? __Yes __No

Patient Signature_____ Date_____

Witness Signature_____ Date_____
(other than family)

HARBOR FOOT & ANKLE CLINIC

FINANCIAL RESPONSIBILITY AND RELEASE OF INFORMATION AGREEMENT

Thank you for choosing Harbor Foot & ankle clinic as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to your upon request.

To the best of my knowledge, the above information is current and accurate. (Please note: Disclosure of Social Security Number is required for our billing/collection process).

I, the undersigned, do hereby acknowledge and accept financial responsibility for the payment of all charges for services rendered to the patient listed above. As a courtesy, we will bill your insurance company(s) as needed. In the event of default of payment and/or failure to pay, I agree to pay the costs of collection, including all court costs and any reasonable attorney fees.

I understand and agree that any check returned to us for insufficient funds will be charged an NSF check fee of $50.00.

I understand and agree that co-payments are due at the time of service. If copayment is not paid at the time of service, a $5.00 billing fee may be applied.

I understand an agree to pay $4.00 monthly late fees on unpaid private balances due which are 60 days or older. Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. Partial payments will not be accepted unless otherwise approved by our Billing Department Manager. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. If this occurs, you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

I understand and agree to pay $50.00 fee for each no-show appointment, and if I cancel 3 appointments consecutively, I may be dismissed from your practice. (Any appointment for which I do not give adequate notice of cancellation as defined by the policies of Bijan Sheikhizadeh, DPM.)

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I authorize the release of medical information to my primary care provider, to referring physicians or consultant(s), if needed, and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of any insurance of Medicare benefits be made on my behalf directly to the provider of services for any services furnished to the above-named patient.

Patient Signature_____

Date_____

NOTICE OF PRIVACY PRACTICES

We Care About Your Privacy

1. Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment:
We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment:
We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations:
We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures:
In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

Facility Directory:
Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name, your location in our facility, your condition described in general terms, your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification:
We may use and disclose medical information to notify or help notify a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief:
We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

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Research in Limited Circumstances:
We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner:
To help them carry out their duties, we may share the med-

ical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions:
Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings:
We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities:
As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence:
We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation:
We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities:
We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement:
Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders:
We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services:
We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. Your Individual Rights

You Have the Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photo copies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

Questions and Complaints

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer.

If you think that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. To take either action, please inform the receptionist that you wish to contact the Privacy Officer or request a complaint form. You may submit a written complaint to the U.S. Department of Health and Human Services; we will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

*These privacy practices are currently in effect and will remain in effect until further notice.