HARBOR FOOT & ANKLE CLINIC

Dr. Bijan Sheikhizadeh, D.P.M
Podiatric Medicine & Surgery Board Certified

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.

Please fill out the enclosed paperwork using clear, legible handwriting. Bring these papers and your **current insurance card(s)** to your appointment. **All copays are due at the time of visit, no exception. Any new patient with Commercial Insurance that's not met their deductible will need to pay $100.00 plus any copay listed on their insurance card. To find out if you've met your deductible you will need to contact your insurance company.**

Please note failure to check in at your appointed check in time or not having paperwork filled out, no ID or proof of Insurance will result in rescheduling your appointment and a fee of $50. 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.

1720 Sumner Ave, Aberdeen, WA 98520
Telephone 360-533-7388 Toll Free 866-525-FOOT Fax 360-533-2529 www.aberdeenpodiatry.com

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

Falls
( ) Falls due to loss of balance or Instability. Number of falls_____ In a year and number of injuries? _____

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 of Patient or Authorized Representative 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 authorize Dr. Sheikhizadeh 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
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 answering machine or voice mail? __Yes __No

Patient Signature_____ Date_____

Witness Signature_____ Date_____

(other than family)

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 Sheikhizadeh, 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

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 you 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_____