Babak Kosari, D.P.M., Inc.

HIPPA PATIENT CONSENT FORM

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS SUMMARY CAREFULLY

1. OUR LEGAL DUTY:
We are required by law to protect the privacy of your health information, to provide a notice concerning privacy practices, to follow the privacy practices that we describe in our Notice of Privacy, and seek your acknowledgement of receipt of this notice. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you and how you can get access to this information. Our notice contains a Patient's Rights section describing your rights under the law. You have the right to review and request a copy of our notice of privacy practices before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

2. How we may use and disclose your health information:
By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment, and health care operations. For example, your health information may be shared with other providers to whom you are referred. You have the right to revoke this consent by requesting that in writing. However, such revocation shall not affect any disclosure we have already made in reliance upon your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

3. Your Rights:
You have the right to look at or get a copy of your health information, and if you request a copy, we may charge you a fee. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operation. We are not required to agree to this restriction, but if we do we shall honor the agreement. You may also request that we correct the information or add any missing information.

4. Privacy Complaints:
If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with the decision we have made about access to your health information, you may contact our Privacy Officer listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

The patient understands that:
1. Protected health information may be disclosed or used for treatment, payment, or health care operations.
2. Our Practice has a Notice of Privacy Practices and that you the patient, have the opportunity to review this notice.
3. The Practice reserves the right to change this Notice of Privacy Practices.
4. The patient has the right to restrict the uses of their information but the Practice does not have to agree to these restrictions.
5. The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
6. The Practice may condition receipt of treatment upon the execution of this consent.
7. If you have any questions or complaints, please contact our Privacy Office.

Privacy Office: Babak Kosari, DPM

INSURANCE INFORMATION

Name of Insurance Co: ______________________ ID #/Group #: ______________________

Name of Insured: ______________________ ID #/Group #: ______________________

Other Insurance: ______________________ Copay: ______________________

DOB: ______________________ SSN#: ______________________

Relationship to patient: ______________________

ASSIGNMENT & RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with above insurance company(s) and assign directly to **Dr. Babak Kosari** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my health insurance plan. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.
I authorize the use of this signature on all insurance submissions. I also certify that I have read and understand the HIPPA PATIENT CONSENT FORM.

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be necessary in the diagnosis and/or treatment of my condition.

Patient's Signature: ______________________________ Date: ______________________

PATIENT INFORMATION

Last Name: ______________ First Name: ______________ Middle Initial: ____

Street Address: ______________ Home Phone: ______________

City: ______________ Mobile Phone: ______________

State: ________ Zip: ________ Work Phone: ______________

Date of Birth: ________ Age: ____ **SOCIAL SECURITY NO**: ______________

Occupation: ______________ WHO SENT YOU TO THIS OFFICE? ______________

Employer: ______________

Employer Phone: ______________ PRIMARY DOCTOR's NAME & PHONE NUMBER: ______________

Emergency Contact: ______________

Emergency Phone: ______________

MEDICAL HISTORY

WHY ARE YOU HERE TODAY?

____

____

DO YOU HAVE PAIN? Y N

FOR HOW LONG?

_________ DAYS
_________ WEEKS
_________ MONTHS
_________ YEARS

PAIN TYPE (Please circle):

SHARP DULL BURNING THROBBING

WHERE is the pain: Right Left

____

HOW IS YOUR CONDITION?

WORSE BETTER NO CHANGE

Previous treatment: ______________

Worse with: ______________

Better with: ______________

ARE YOU TAKING PAIN MEDICATION?

____

DO YOU HAVE:

Diabetes Mellitus	Y	N
Hypertension	Y	N
Kidney Disease	Y	N
On Dialysis	Y	N
Cancer	Y	N
Heart Disease	Y	N
Arthritis	Y	N
Stroke	Y	N
Fever	Y	N
AIDS	Y	N

Other: ______________

LAST VISITS TO:

Primary Doctor: ______________

Eye Doctor: ______________

LAST TIME YOU WERE AT:

Hospital: ______________

HAVE YOU HAD ANY:

Foot Surgery: Y N

____

DESCRIBE

Do you smoke? Y N

How long? ______________

Do you drink alcohol? Y N

How much? ______________

FAMILY HISTORY OF:

Diabetes Mellitus	Y	N
High Blood Pressure	Y	N
Kidney Disease	Y	N
Cancer	Y	N
Heart Disease	Y	N

Other: ______________

DRUG ALLERGIES:

____

MEDICATIONS:

____

____

____

DO YOU TAKE BLOOD THINNING MEDICATION LIKE CUMADIN OR ASPIRIN?

Y N