Syamak Yamini DPM, FACFAS

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Porter Ranch, CA 91326
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PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Last Name First Middle	☐ Mr. ☐ Mrs. ☐ Dr. ☐ Miss ☐ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid
Nickname (Name I preferred to be called)	Birth Date (mm/dd/yyyy) / Sex ☐ M ☐ F	Spouse's Name
Street Address	Social Security #	Home Phone # ( )
City State Zip Code	E-Mail	Mobile Phone # ( )
Employer / Employer Address		Employer/Work Phone # ( )
Pharmacy Name & Phone #	Primary Care Physician (PCP)	Date PCP Last Seen

PERSON RESPONSIBLE FOR BILL (IF DIFFERENT THAN ABOVE)

Name of Person Responsible for Bill	Birth Date (mm/dd/yyyy) / Sex ☐ M ☐ F	Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other
Street Address	Social Security #	Home Phone # ( )
City State Zip Code	E-Mail	Mobile Phone # ( )
Employer / Employer Address		Employer/Work Phone # ( )

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD AND PHOTO ID TO RECEPTIONIST)

Primary Insurance	Subscriber Name	Birth Date (mm/dd/yyyy)	Social Security #

Insurance ID #	Group #	Policy #	Effective Date	Expiration Date	Co-Payment $

Secondary Insurance	Subscriber Name	Birth Date (mm/dd/yyyy)	Social Security #

Insurance ID #	Group #	Policy #	Effective Date	Expiration Date	Co-Payment $

IN CASE OF EMERGENCY

Name of Nearest Friend or Relative	Relationship to Patient	Home Phone # ( )	Work or Mobile Phone # ( )

REFERRAL

How did you learn about us? (Please check all that apply) ☐ Dr. _____ ☐ Hospital/ER ☐ Lecture ☐ Insurance Plan

☐ Phonebook ☐ Internet ☐ Website ☐ Friend/Family: _____ ☐ Other: _____

The above information is true to the best of my knowledge. I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Syamak Yamini DPM all insurance and benefits , if any, otherwise payable to me for service(s) rendered. I understand that I am 100% financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature below on all insurance submissions. Syamak Yamini DPM may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X _____ _____

PATIENT/GUARDIAN SIGNATURE DATE

Syamak Yamini DPM, FACFAS

COMPREHENSIVE HEALTH REVIEW

Patient Name:_____ **Date of Birth**:_____ **Today's Date**: _____

HISTORY OF PRESENT ILLNESS / WHAT BRINGS YOU IN?

What is your specific foot/ankle problem? _____

_____

_____

When did the problem begin? _____

Which foot/ankle is involved? □ Right □ Left □ Both

First visit to a doctor for this problem? □ Yes □ No

Have you had a similar problem in the past? □ Yes □ No

How was the problem onset? □ Sudden □ Gradual

The problem is: □ Improving □ Worsening □ Unchanged

The problem is worst: □ AM □ PM □ At Rest □ With Activity

What aggravates the problem? _____

What improves the problem? _____

Is the problem painful? □ Yes □ No If so, rate your current pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Describe the pain: □ Sharp □ Dull □ Aching □ Throbbing □ Cramping □ Itching □ Popping

□ Burning □ Tingling □ Clicking □ Shooting □ Stabbing □ Other: _____

Describe previous treatments: _____

Is this from an injury? □ Yes □ No If so, is it work-related? □ Yes □ No _____

PAST MEDICAL HISTORY

□ Diabetes Type 1 2 Duration_____years Last Blood Sugar_____HbA1c_____

□ Acid Reflux
□ Anemia
□ Anesthesia Complications
□ Arthritis (□ Rheumatoid / □ Systemic)
□ Asthma
□ Back Problems/Sciatica
□ Blood Clot/DVT
□ Cancer:_____
□ Cellulitis/Skin Infection (□ MRSA?)
□ Circulation Problem
□ Dementia/Alzheimer's
□ Excessive/Easy Bleeding
□ Fibromyalgia
□ Foot/Leg Ulcer
□ Gout
□ Healing Problems/Keloids
□ Heart Disease/Heart Attack
□ High Blood Pressure (□ Low BP?)
□ High Cholesterol
□ Hormone Therapy
□ Immune Disorder/HIV
□ Kidney Disease (□ Dialysis)
□ Other problems not listed: _____

□ Liver Disease (□ Hepatitis)
□ Lung Condition:_____
□ Lupus
□ Mitral Valve Prolapse/Murmur
□ Multiple Sclerosis
□ Nervous Disorder/Depression
□ Neuropathy
□ Osteomyelitis/Bone Infection
□ Parkinson's Disease
□ Previous Addiction to:_____
□ Pulmonary Embolism
□ Rashes/Skin Condition
□ Raynaud's Disease/Phenomena
□ Seizure Disorder/Epilepsy
□ Sickle Cell Disease/Trait
□ Sleep Apnea
□ Stomach Ulcers
□ Stroke □ Rt □ Lt (year_____)
□ Thyroid Condition (□ Hi □ Lo)
□ Varicose Veins
□ Women – Are You Pregnant or Breast Feeding?

PAST SURGERIES

□ Foot/Ankle Surgery: _____
□ Joint Replacement: _____
□ Open Heart/Bypass Surgery
□ Hysterectomy □ Tubal ligation □ C-Section
□ Stent Placement: Heart Leg
□ Cosmetic Surgery: _____
□ Appendix □ Gallbladder □ Tonsils/Add
□ Leg Bypass □ Open Fracture Repair
□ Carotid Surgery □ Vein Surgery
□ Hernia Repair □ Thyroid □ Back Surgery
□ Other: _____

FAMILY HISTORY (circle relative)

Mother **F**ather **S**ister **B**rother **G**rand**P**arent

□ Cancer M F S B GP
□ Diabetes M F S B GP
□ Gout M F S B GP
□ Heart Disease M F S B GP
□ High Blood Pressure M F S B GP
□ Severe Arthritis M F S B GP
□ Anesthesia Complications M F S B GP
□ Foot Problems M F S B GP
□ Other: _____ M F S B GP

Syamak Yamini DPM, FACFAS

COMPREHENSIVE HEALTH REVIEW

Patient Name: _____

MEDICATIONS (include RX meds, OTC meds, and vitamins)

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

ALLERGIES

- ☐ **None**
- ☐ Adhesives/Tape
- ☐ Aspirin
- ☐ Codeine
- ☐ Cortisone
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Seafood/Shellfish
- ☐ Sulfa Drugs
- ☐ _____

SOCIAL HISTORY

Occupation: _____

☐ I Drink Alcoholic Beverages How much/often? _____

☐ I Use or Have Used Tobacco Products Type: _____

Packs/Day _____ Years _____ When Stopped? _____

☐ I Use or Have Used Drugs that are Illegal _____

I Live With: ☐ No One ☐ Spouse ☐ Children ☐ Parents ☐ Other

I Stand _____% of My Day

I Exercise Each Week: ☐ 0 days ☐ 1-2 days ☐ 3+ days

List Sports/Activities: _____

☐ My foot/ankle problem limits my activities

I am: ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Widowed

REVIEW OF SYSTEMS

CONSTITUTIONAL
- ☐ Recent Weight Changes
- ☐ Fever/Chills
- ☐ Nausea or Vomiting
- ☐ Fatigue

EYES
- ☐ Eye Disease/Injury
- ☐ Wear Glasses/Contacts
- ☐ Blurred or Double vision
- ☐ Glaucoma

EARS/NOSE/MOUTH/THROAT
- ☐ Hearing Loss
- ☐ Nose Bleeds
- ☐ Sore Throat/Voice Change
- ☐ Sinus Problems
- ☐ Difficulty Swallowing

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Arrhythmia/Irregular Heart Beat
- ☐ Leg Pain when Walking
- ☐ Swelling of Hands/Feet

MUSCULOSKELETAL
- ☐ Muscle Pain or Cramps
- ☐ Joint Pain
- ☐ Stiffness/Swelling Joints
- ☐ Low Back Pain
- ☐ Trouble Walking

GASTROINTESTINAL
- ☐ Indigestion/Heartburn
- ☐ Diarrhea
- ☐ Blood in Stools
- ☐ Stomach Pains

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Chronic/Frequent Cough
- ☐ Wheezing

GENITOURINARY
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Kidney Stones
- ☐ Blood in Urine

INTEGUMENTARY
- ☐ Rash or Itching
- ☐ Dry Skin
- ☐ Change in Hair/Nails

HEMATOLOGICAL
- ☐ Bruise Easily
- ☐ Slow to Heal

ENDOCRINE
- ☐ Hormonal Problem
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Too Hot/Too Cold

NEUROLOGICAL
- ☐ Migraines
- ☐ Frequent Headaches
- ☐ Numbness/Tingling
- ☐ Dizzy Spells
- ☐ Paralysis/Tremors

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Nervousness
- ☐ Insomnia
- ☐ Confusion/Memory Loss

STATS

For Office Staff

Age _____ Height _____ Weight _____ Shoe Size _____ BP _____ P _____ O2 Sat _____ Temp _____ BMI _____

I understand that completing this paperwork is a chore. The information I have provided is true to the best of my knowledge. I recognize that the information I have provided will help me receive better care.

X _____ _____

PATIENT/GUARDIAN SIGNATURE DATE

Syamak Yamini DPM, FACFAS

FINANCIAL POLICY

1. All co-payments are due at the time of visit. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered a violation of the contract you have with your insurance company. Our office accepts cash, credit and debit cards.
2. Co-insurance and unmet deductibles are due prior to scheduled surgeries and procedures. Once benefits are verified and your financial responsibility calculated, you will be notified of the payment amount and due date.
3. You are 100% responsible for payment of charges for services you receive from our office.
4. In accordance with your insurance member handbook, it is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company.
5. It is your responsibility to ensure that our physicians are in your insurance network.
6. If your plan requires a referral, it is your responsibility to obtain this prior to being seen by our provider.
7. Payment is due for rendered services 10 days from receipt of your billing statement. Outstanding balances must be paid in full prior to any additional visit unless arrangements have been made with our billing department.
8. There is a service fee of $35 for each time a check is returned. The bank may return your check up to three times before considering it nonnegotiable. Your insurance company does not cover this fee.
9. A scheduled appointment means that time has been reserved for you. Cancellations for appointments must be received at least 24 hours prior to the scheduled appointment. Cancellations for scheduled surgery and in-office procedures must be received at least 7 days prior to the scheduled surgery date and time.
10. Patients who fail to keep or cancel a scheduled appointment may be charged a $25.00 No Show Fee. There is a $400.00 cancellation fee for scheduled surgeries & $100.00 cancellation fee for in-office procedures that are cancelled less than 5 business days from the date and time of surgery/procedure unless cancellation is due to insurance denial or medical necessity.
11. Medical records requests must be received in writing at least 72 hours prior to the date needed. Fees for medical records are set depending if patient has an outstanding balance and/or an attorney is requesting on your behalf. Fees must be received prior to record delivery. No more than 5 pages may be faxed.
12. Administrative Services: There is a $15.00 charge for each required Administrative Service, payable prior to service completion. This Administrative Service Fee covers specific administrative services such as forms completion for medical leave and disability (EDD Form), DMV disabled person placard, and any other administrative items not covered by insurance.
13. HMO/PPO: **ALL CO-PAYMENTS ARE DUE AT THE TIME OF YOUR APPOINTMENT (S)**
    We are in network with most ,but not all insurance plans. You are responsible for verifying that Syamak Yamini DPM is in network with your plan. If you are an HMO member, you will not be billed as long as we have a unused & valid referrals. **Please note:** You must have your referral at the time of the visit or your plan requires that we ask you to reschedule. PPO patients will only be responsible for their remaining deductible amount, co payments ts and co insurance ce, as long as they have verified with their insurance that our physician is in their plan.
14. SELF-PAY: Payment in full is due at the time of service if you do not have health insurance coverage.

NOTICE OF PRIVACY
PRACTICES PATIENT ACKNOWLEDGMENT

Patient name:_____ Date of Birth:_____

I have received this practices notice of privacy practices written in a plain language. The notice provides in detail the uses and disclosures of my protect health information that may be made by this practice, my individual rights and the practices legal duties with respect to my protect health information. The notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required by law to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make to each of the following purposes: Treatment, payment, and healthcare operations.
- Description of uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protect health information and a brief description of how I made exercises these rights in relation to:

    - The right to complain to this practice and to the secretary of human health services if I believe my privacy rights have been violated, and no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communication of protected health information.
    - The right to inspect and copy protects health information.
    - The right to amend protects health information.
    - The right to receive an accounting of disclosures of protected health information
    - The right to obtain a paper copy of the notice of privacy practices from this practice upon request

This practice reserves the right to change the terms of its notice of privacy practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice current notice of privacy practices on request.

Patient's Signature:_____Today's Date_____

_____

Relationship to patient (if signed by patient's Representative)

Syamak Yamini DPM, FCFAS

CONSENT TO TREATMENT

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Patient Initials: _____

AUTHORIZATION REGARDING PRIVACY POLICY

Due to the recent implementation of the Patient Privacy Act (HIPPA), I hereby authorize Syamak Yamini DPMto leave messages at my home with family members and/or answering machines regarding the following: (1) Confirm or Change Appointment, (2) Results of testing ordered by the physician, and/or (3) Any pertinent information that may be relative to my care.

Patient Initials: _____

ACKNOWLEDGMENT OF RECEIPT OF FINANCIAL POLICY

I acknowledge that I was provided a copy of Syamak Yamini DPM Financial Policy and that I have read (or had the opportunity to read if I so chose), understand and will comply by the policies stated.

Patient Initials: _____

CONSENT TO VIEW EXTERNAL PRESCRIPTION HISTORY

I authorize Syamak Yamini DPM to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff at Syamak Yamini DPM and it may include prescriptions back in time for several years.

Patient Initials: _____

PATIENT CONSENT

I hereby voluntarily consent to outpatient care by a Syamak Yamini DPM Podiatrist, encompassing routine care, diagnostic procedures, examination and medical treatment including, but not limited to, minor surgical procedures, ultrasound, photographs and administration of medications and injections prescribed by the Syamak Yamini DPM Podiatrist. I agree to ask questions to clarify treatment should I not understand the treatment plan.

Patient Initials: _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Syamak Yamini DPM and its Podiatrists, all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am 100% financially responsible for all charges whether or not paid by my insurance. I agree that should my account become delinquent and is referred to an attorney or collection agency for collection, I will be charged an additional 33% of any unpaid balance at the time of referral for all costs of collection and attorney's fees. I authorize the use of my signature below on all insurance submissions. Products and DME, dispensed to you will be either billed to your insurance or paid by cash. Prices for items billed to your insurance are based on their specific Fee Schedule.

Syamak Yamini DPM may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient Initials: _____

I have read and fully understand this Consent to Treatment. This authorization is valid as of the date I have signed below and will remain in effect as long as I am a Valley Foot & Ankle Center patient. I have read this complete page and agree to all of its contents.

Name of Individual/Legal Representative (Print)	Signature of Individual/Legal Representative	Date