WEST PLANO MEDICAL ASSOCIATES
SAFOORA "SOPHIE" HARANDI, M.D

Allergy History

Patient: DOB _____/_____/_____

Contact Number: Date:

Email:

Check Conditions Affecting Symptoms

1) During which months do symptoms occur?

□ All Months

□ January	□ March	□ May	□ July	□ September	□ November
□ February	□ April	□ June	□ August	□ October	□ December

2) Are your symptoms worse?

□ Morning	□ Afternoon	□ Evening	□ Night
□ At home	□ At work/School	□ Other location: _____	

3) Are symptoms?

□ Constant	□ Erratic	□ Rare

4) Do symptoms interfere with your activities?

□ Not at all	□ A little	□ Moderately	□ All the time

5) Family History:

□ Asthma	□ Eczema	□ Sinus problems	□ Migraines
□ Hay Fever	□ Ulcer	□ Nervous Disorder	□ Colitis

□ Other:_____

6) Please rate your symptoms 1 – 5 (#1 is low degree of symptom, #5 is high degree of symptom)

CIRCLE THE NUMBER					
Eyes (itchy, watery or swelling)	1	2	3	4	5
Ears (itchy, draining or congested)	1	2	3	4	5
Nose (runny or congested)	1	2	3	4	5
Headaches (allergy related)	1	2	3	4	5
Cough (allergy related)	1	2	3	4	5
Sneezing	1	2	3	4	5

7) Are you currently being treated for allergies? Yes No

8) Are you interested in being allergy tested? Yes No

Signature : _____ **Date:**

3060 Communication Pkwy, Ste 204 Plano, TX 75093 (972) 312-8429 Fax: (877) 873-0751

WEST PLANO MEDICAL ASSOCIATES
SAFOORA "SOPHIE" HARANDI, M.D

Circle your provider: ***Dr.Safoora, Harandi*** ***Kasey L. Bryant, FNP-C***

Patient's Name _____ Date:

Allergies / sensitivities to medication:

Current Medications (Use back if needed:

Past and current medical conditions you have had (Please circle):

Diabetes 1 or 2	Cancer	Pneumonia	Stroke/TIA	Liver disease
Heart attack/stent	Thyroid high / low	Autoimmune	Depression	Eye problems
Heart surgery	Asthma	Blood clots	Anxiety	Infectious disease
High blood pressure	Seasonal Allergies	Bleeding tendency	Seizures	Erectile dysfunction
High Cholesterol	Sleep Apnea	Reflux	Kidney disease	Colon polyps

Other medical conditions/details not listed above:

WEST PLANO MEDICAL ASSOCIATES
SAFOORA "SOPHIE" HARANDI, M.D

Past Surgeries:

Family History – list illness in blood relatives – especially Heart, Diabetes, Cancer (type and age of onset), Blood Pressure, Cholesterol, Thyroid, Dementia, Stroke, Depression/Anxiety, Kidney and Liver disease.

Mother:
Father:
Siblings:
Premature disease in 2nd degree(grandparents, aunts, uncles, cousins) relative:

Lifestyle Habits:

Tobacco Use – Type and daily quantity:	Number of years:
Alcohol Use – servings and type per week:	
Caffeine intake - servings and type per day:	
Happy with current weight? Yes / No	If not, please provide goal weight:
Exercise type, duration and frequency:	

Preventive Services:

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SAFOORA "SOPHIE" HARANDI, M.D

Disease immunized against and approximate date if known or circle – Conscientious Objector

Influenza:	Tetanus:	Pneumonia:	Shingles:

Last screening date if age/sex appropriate:

Pap smear (age 21-65 for females::
Mammogram (age 50 and abofe for females):
Colorectal cancer screening (age 50 and above):

Risk factors for Hepatitis C or other infectous/contagious diseases if applicable: _____

_____
Preferred Pharmacy (Retail and/or 90 day Mail-in):

_____
Email address (for portal access):

PATIENT'S PERSONAL INFORMATION

Today's Date:

Patient Last Name	First Name	Middle Name	Alias Name
Address (Street or Box	City	State	Zip

WEST PLANO MEDICAL ASSOCIATES
SAFOORA "SOPHIE" HARANDI, M.D

Home Phone ☐imary Number	Work Phone ☐rimary Number	Mobile Phone ☐rimary Number
Email (Allos us to send you important messages.)	Marital Status ☐ngle ☐Married ☐ivorced ☐Widowed	
Sical Security Number:	Sex ☐Male ☐emaile	Date of Birth
Employer Name	Employer Address	
How did you hear about the provider you are seeing today?		
Emergency Contact Name:	Relationship to Patient	Phone

Primary Insurance Company	Effective Date	Secondary Insurance Company	Effective Date
Claims Mailing address (Street or Box)		Claims Mailing address (Street or Box)	
City / State / Zip		City / State / Zip	
Policy ID Number	Group ID Number	Policy ID Number	Group ID Number
Subscriber Name	Date of Birth	Subscriber Name	Date of Birth
Subscriber Social Security #	Relationship to Patient	Subscriber Social Security #	Relationship to Patient
Subscriber Employer	Work Phone #	Subscriber Employer	Work Phone #
Subscriber Employer address (Street or Box)		Subscriber Employer address (Street or Box)	
City / State / Zip		City / State / Zip	

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent/s have insurance coverage with_____ and directly assign to Safoora Harandi, M.D. all insurance benefits, that are payable to her for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by the insurance. I authorize the use of my signature on all insurance claims. My signature is valid even if this form is photocopied. Dr. Harandi can use my personal healthcare information and may disclose such information to the above-named insurance company or companies and their agents for obtaining payment for services and determining insurance benefits payable for related services.

_____

Signature of Patient, Spouse, Parent, Guardian, or Personal Representative

Your Information. Your Rights. Our Responsibilities.

3060 Communication Pkwy, Ste 204 Plano, TX 75093 (972) 312-8429 Fax: (877) 873-0751

WEST PLANO MEDICAL ASSOCIATES
SAFOORA "SOPHIE" HARANDI, M.D

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

- Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases, we never share your information unless you give us written permission: ● Marketing purposes ● Sale of your information ● Most sharing of psychotherapy notes	In the case of fundraising: ● We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways. **Treat you** We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition*.	**Run our organization** We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*
Run our organization We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services*	**Bill for your services** We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan, so it will pay for your services.
How else can we use or share your health information? We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html	**Help with public health and safety issues** We can share health information about you for certain situations such as: ● Preventing disease ● Helping with product recalls ● Reporting adverse reactions to medications ● Reporting suspected abuse, neglect, or domestic violence ● Preventing or reducing a serious threat to anyone's health or safety
Do research We can use or share your information for health research	**Comply with the law** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law
Respond to organ and tissue donation requests We can share health information about you with organ procurement organizations	**Work with a medical examiner or funeral director** We can share health information with a coroner, medical examiner, or funeral director when an individual dies
Address workers' compensation, law enforcement, and other government requests We can use or share health information about you: ● For workers' compensation claims ● For law enforcement purposes or with a law enforcement official ● With health oversight agencies for activities authorized by law ● For special government functions such as military, national security, and presidential protective services	**Respond to lawsuits and legal actions** We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Our Responsibilities ● We are required by law to maintain the privacy and security of your protected health information. ● We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. ● We must follow the duties and privacy practices described in this notice and give you a copy of it. ● We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.	**Our Responsibilities** ● We are required by law to maintain the privacy and security of your protected health information. ● We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. ● We must follow the duties and privacy practices described in this notice and give you a copy of it. ● We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.l

WEST PLANO MEDICAL ASSOCIATES
SAFOORA "SOPHIE" HARANDI, M.D

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Effective Date June 2013
- Privacy Officer: Dr Safoora Harandi
  reception@sharandimd.com
  972-312-8429
- We never market or sell personal information
- We will never release records pertaining to sensitive subject matter including: Mental Health Records, Substance Abuse Records, Genetic Information, or HIV/AIDS Tests Results/Treatment, without additional consent from you.

PATIENT
SIGNATURE_____ DATE_____

WEST PLANO MEDICAL ASSOCIATES
SAFOORA "SOPHIE" HARANDI, M.D

PRACTICE INFORMATION AND AUTHORIZATION OF POLICIES

Dear Valued New and Established Patients,

We warmly welcome you to Dr Harandi's medical practice! Each and every day, we strive to do our very best to help you and to please you. To help us accomplish these goals, won't you please take a few minutes to read/sign this simple form? It will help you to familiarize yourself with our office practices and make for better understanding between us. Thank you so very much.

****

OFFICE HOURS

Monday through Friday: 8:30AM to 5:00 PM (24-hour answering service)

SCHEDULING

Appointments are scheduled to allow the Doctor to devote all of her attention to individual patients during scheduled visits. As a courtesy to her, the office staff, and other patients, we ask that you schedule your appointment when you are certain that you will be able to keep it-and arrive on time.

FAILURE TO KEEP YOUR APPOINTMENT OR ARRIVING LATE

Many behind-the-scenes preparations are made before patients arrive, so any time a patient fails to keep an appointment, or is late for it, that time-slot (and, possibly, expensive medication and supplies that are readied for your use) is wasted. We realize that sometimes due to unexpected or extenuating circumstances, an appointment just cannot be kept. Nonetheless, a 24-hour notice is required if you cannot keep yours. **If you do not notify us at least 24 hours in advance, a $35.00 fee will be charged for the appointment time that was reserved for you.** (Patients who arrive 15 minutes late for their appointment will be asked to reschedule.)

KEEPING YOUR INFORMATION CURRENT

Please notify the office when there are any changes to your home address, phone number, or insurance plan.

SPECIAL CONTACTS WITH YOUR INSURANCE COMPANY

There is a **$10.00 fee** when it is necessary to contact your insurance company to request special authorizations (for medications, procedures, or supplies) that are outside your plan.

COLLECTION FEES

All deductable / copay are due at the time of service. Deductibles are an estimate of amount due. There may be additional payment due. If unable to pay at time of visit, you will not be seen and the appointment will be rescheduled. Should an account be sent to a collection agency for non-payment, **an additional 30%** will be added to the principle balance.

PRESCRIPTION REFILLS

WHENEVER YOU NEED A PRESCRIPTION REFILLED, PLEASE DO NOT CALL THE OFFICE, UNLESS IT IS A CLASS 4 CONTROLLED MEDICATION. Instead call the pharmacy and give your pharmacist our fax number to request the medication(s) you need. Please allow 48 hours for prescriptions to be processed and filled-and remember that there are times when an office visit is required to obtain your prescription.

PERMISSION TO LEAVE MESSAGES ON YOUR VOICEMAIL

I give my permission for West Plano Medical Associates and its representatives to leave voice messages on my home phone, on my work phone, and on my cell phone. **(Please check one: ___Yes ___No)**

Thank you for your cooperation and for your visit. We look forward to a pleasant, healthful, and long-term relationship with you.

_____ _____

Signature Date

_____

Please Print Your Name Here

3060 Communication Pkwy, Ste 204 Plano, TX 75093 (972) 312-8429 Fax: (877) 873-0751

WEST PLANO MEDICAL ASSOCIATES
SAFOORA "SOPHIE" HARANDI, M.D

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS OR PATIENT DESIGNATED TRANSLATOR

Patient Name_____ Date of Birth _____

Many of our patients allow family members such as their spouse, parents or others to request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below. I authorize West Plano Medical Associates to release my medical and/or billing information to the following person(s):

1. Name_____

   Relationship to patient: _____ Phone Number: _____

2. _____

   Relationship to patient: _____ Phone Number: _____

3. _____

   Relationship to patient: _____ Phone Number: _____

PATIENT INFORMATION:
I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

_____ _____
Signature **Date**

3060 Communication Pkwy, Ste 204 Plano, TX 75093 (972) 312-8429 Fax: (877) 873-0751

WEST PLANO MEDICAL ASSOCIATES
SAFOORA "SOPHIE" HARANDI, M.D

NOTICE TO PATIENTS
DISCLOSURE OF PHYSICIAN OWNERSHIP

Please review carefully the information contained in this notice.

1. During the course of our physician/patient relationship, I may refer you to Physicians Medical Center, LLC. d/b/a Texas Health Center for Diagnostics & Surgery Plano (Hospital) or one or more other physicians who provide specialized medical services.
2. I want to inform you that I am very aware of the services provided at this Hospital because I have an ownership interest in it. Further, If I refer you to another physician for specialized medical services that physician also could have an ownership interest in the Hospital.
3. I am providing this information to help you make an informed decision about your health care. You have the right to choose your health care provider. Therefore, you have the option to use a health care facility other than the Hospital or physicians to whom I might refer you from time to time.
4. I will not be treating you differently if you choose to obtain health care at a facility other than the Hospital and, if you desire, I will be happy to provide you information about alternative health care providers.

If you have any questions, please do not hesitate to ask. We welcome you as a patient, and we value our relationship with you.

By signing below, you acknowledge that you have read and understand this notice, and that you are aware of my ownership interest in the hospital. Should you be referred to the hospital or to another physician who holds an ownership interest in the hospital, you acknowledge your decision to decline the option to have your health care provided at another health care facility. You further acknowledge that you signed this notice prior to my referral of you to the hospital or another physician.

_____
Signature of Patient

_____
Signature of Parent or Guardian
(If applicable)

_____
Printed Name

_____
Date

3060 Communication Pkwy, Ste 204 Plano, TX 75093 (972) 312-8429 Fax: (877) 873-0751

WEST PLANO MEDICAL ASSOCIATES
SAFOORA "SOPHIE" HARANDI, M.D

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____ _____ _____
Last First Middle
OTHER NAME(S) USED _____

Date of Birth Month ____Day ____ Year_____

ADDRESS _____
_____
CITY _____**STATE**_____ **ZIP**_____
PHONE (_____)_____ **ALT. PHONE** (_____)_____
EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING T O DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTHINFORMATION:

Person/Organization Name: ____ _____
Address: _____
City _____ State ____ Zip Code _____
Phone (____) _____ Fax (____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?
Person/Organization Name: ____**Safoora Harandi MD**_____
Address: ____3060 Communications Pkwy Ste 204_____
City _____Plano_____ State TX__ Zip Code ___75098_____
Phone **(972) 312-8429**_____ Fax **(877) 873-0751**_____

Reason for Disclosure
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Insurance

What information can be disclosed? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

☐ All health information	☐ History/Physical Exam	☐ Past/Present Medication	☐ Lab Results
☐ Physician's Orders	☐ Patient Allergies	☐ Operation Reports	☐ Consultation Reports
☐ Progress Notes	☐ Discharge Summary	☐ Diagnostic Test Reports	☐ EKG/Cardiology Rpts
☐ Pathology Reports	☐ Billing Information	☐ Radiology Reports & Images	☐ Other _____

Your initials are required to release the following information:
_____Mental Health Records (Excluding Psychotherapy notes)
_____ Drug, Alcohol, or Substance Abuse Records
_____Genetic information (including Genetic Test Results
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD: This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month ____ Day ____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable):_____

If representative, specify relationship to the individual: __ Parent of minor __Guardian __ Other _____
A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

WEST PLANO MEDICAL ASSOCIATES
SAFOORA "SOPHIE" HARANDI, M.D

SIGNATURE X_____ _____

Signature of Minor Individual **DATE**

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