SOHAIL SHAYFER, MD, INC.

Orthopaedic Surgery, Hand Surgery, & Sports Medicine

Diplomate, American Board of Orthopaedic Surgery

QME, State of California

GENERAL PATIENT INFORMATION FORM

Patient Name:________________________________ Sex:________ Birth Date:__________ Age:___

Address:____________________________ City/State:__________________ Zip:____________

Home Phone:________________ Work Phone:____________________ Cell Phone____________

Drivers License #:____________________________ E-mail address:______________________

Social Security #:______________ Occupation:__________________ Employer:______________

Name of Spouse:________________________ Spouse's cell Phone:________________________

Referred By:______________________________ Phone #:______________________________

In Case of Emergency Contact:_________________________ Phone #:_____________________

Address:____________________________________ Relationship:________________________

Name of Insured/Guarantor (if not the patient) :__________________ Relationship to Insured:______________

Guarantor's DOB:___________________ Guarantor's social security:______________________

Insurance Carrier:________________________ Insurance address:_______________________

Policy #:______________ Cert.#:____________________ Group #:_______________________

If injured. date of injury:________________ Where did injury occur?:______________________

If Injured. was injury related to Work:______________ auto Accident:_____________________

If auto accident. auto policy name and number:______________________________________

Is there an attorney involved?______________ Attorney's name:__________________________

Phone #:______________ Address:____

* * * * * * * * * * * * * *

I CERTIFY THAT THE ABOVE IS CORRECT. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM. I ALSO REQUEST PAYMENT OF BENEFITS PAYABLE TO THE PARTY WHO ACCEPTS ASSIGNMENT. I AUTHORIZE DR. SOHAIL SHAYFER TO EXAMINE ME. I UNDERSTAND THAT IF SURGERY IS INDICATED. PAYMENT ARRANGEMENTS WILL BE MADE AND I AM RESPONSIBLE FOR MY BILL REGARDLESS OF INSURANCE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. I UNDERSTAND THAT PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED.

SIGNED:____ DATE:__________________

SIGNATURE OF PARENT OR GUARDIAN:______________________ RELATIONSHIP:______________

Rev;3/20/07

Preferred pharmacy:__________________ City ______________ Phone # __________________

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Medical History Form

A complete history is invaluable in evaluation and management of most medical conditions. Seemingly unrelated conditions can be the key to discovering the correct diagnosis. Accordingly, we appreciate if you fill out the following form as thoroughly as possible.

Date: ____________________ Referred by: ______________________________

Name (Print): __________________________________ Age: ______

☐ Right/ ☐ Left handed. Occupation: __________________ Weight: _______ Height: ________

Name of Private Medical Doctor: ____

HISTORY OF PRESENT ILLNESS:

List all body parts for which you are being seen today. Indicate right or left.

____

List the symptoms or conditions for which you are being seen today:

____

____

Is today's problem related to an injury? ☐Yes ☐ No . If yes date of injury: ______________________________

Where did the injury take place? ☐ Home ☐Work ☐Other ____

If there was no injury, when did the symptoms first start? ____

Please give a chronological history of progression of your symptoms from onset to present with approximate dates:

____

____

____

Is there is a history of this or similar condition in the past? ____

____

Please list the other physicians you have seen regarding this condition: ____

____

Have you tried any medication, injection, or physical therapy? ____

____

Have they been helpful? ____

Do you have any **allergies** to medications? ☐ yes ☐ no. If yes, please list: ______________________________________

____

____

List all your **medications**:

Medication	Dose	Frequency

PAST MEDICAL HISTORY: Check all that apply

Cardiovascular

☐ Abnormal Heart Rhythm
☐ Carotid Artery Disease
☐ Congestive Heart Failure
☐ Coronary Artery Disease
☐ Deep Vein Thrombosis
☐ High Cholesterol
☐ Hypertension
☐ Heart Attack
☐ Peripheral Vascular Disease
☐ Superficial Vein Clot
☐ Phlebitis
☐ Heart Valve Disease

Pulmonary

☐ Asthma
☐ Chronic Bronchitis
☐ COPD
☐ Cystic Fibrosis
☐ Pneumonia
☐ Pulmonary Embolism
☐ Pulmonary Hypertension
☐ Sleep Apnea
☐ TB

Gastrointestinal

☐ Gall Stones
☐ Cirrhosis
☐ Colon Polyps
☐ Crohn's Disease
☐ GERD
☐ Hepatitis
☐ Irritable Bowel Syndrome
☐ Pancreatitis
☐ Peptic Ulcer Disease
☐ Ulcerative Colitis

Renal

☐ Acute Renal Failure
☐ Benign Prostatic Hypertrophy
☐ Chronic Renal Failure
☐ Endometriosis
☐ Glomerulonephritis
☐ Polycystic Kidney Disease
☐ Kidney Stones
☐ Urinary Incontinance
☐ Frequent Bladder Infections

Musculoskeletal/Connective tissue

☐ Chondromalacia Patellae
☐ Chronic Pain
☐ Degenerative disc disease, cervical
☐ Degenerative disc disease,lumbar
☐ Fibromyalgia
☐ Fractures
☐ Gout
☐ Juvenile Rheumatoid Arthritis
☐ Legg-Calve-Perthes Disease
☐ Osgood-Schlatter Disease
☐ Osteoarthritis
☐ Osteoporosis
☐ Paget's Disease
☐ Polymyalgia Rheumatica
☐ Rheumatoid Arthritis
☐ Sjogren's Disease
☐ Slipped Capital Femoral Epiphysis
☐ Systemic Lupus Erythematosis

Endocrine

☐ Addison's Disease
☐ Carcinoid Syndrome
☐ Cushing's Disease
☐ Diabetes
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Osteoporosis
☐ Panhypopituitarism

Neurological

☐ Alzheimer's Disease
☐ ADD/ADHD
☐ Autism
☐ Cerebral Palsy
☐ Stroke
☐ Dementia
☐ Degenerative Disc Disease with leg pain
☐ Headaches
☐ Huntington's Disease
☐ Mental Retardation
☐ Multiple Sclerosis
☐ Muscular Dystrophy
☐ Myasthenia Gravis
☐ Parkinson's Disease
☐ Sensory Neuropathy
☐ Seizures
☐ TIAs

Hematologic

- ☐ Hemolytic Anemia
- ☐ Iron Deficiency Anemia
- ☐ Myelofibrosis
- ☐ Pernicious Anemia
- ☐ Sickle Cell Disease
- ☐ Thallasemia

Allergy/Immune/Skin

- ☐ Allergies
- ☐ Angioedema
- ☐ Eczema
- ☐ Immune Deficiency
- ☐ Psoriasis

- ☐ Sinusitis (frequent)

Cancers

- ☐ Bone
- ☐ Brain
- ☐ Breast
- ☐ Colon
- ☐ Hepatic/Liver
- ☐ Leukemia
- ☐ Lung
- ☐ Lymphoma
- ☐ Melanoma
- ☐ Pancreatic
- ☐ Prostate
- ☐ Renal/Kidney
- ☐ Skin
- ☐ Testicular
- ☐ Thyroid

Other

- ☐ Cataract
- ☐ Glaucoma
- ☐ Over Weight

Psychiatric

- ☐ Anxiety
- ☐ Anorexia Nervosa
- ☐ Bipolar Disorder
- ☐ Bulimia
- ☐ Depression
- ☐ Obsessive Compulsive
- ☐ Schizophrenia

Please list any significant medical problems that is not listed above: ______________________________

____

Please list all your surgeries: ____

____

____

SOCIAL HISTORY

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Student

Do you smoke? ☐ Never ☐ Quit _____ months/ years ago ☐ Yes: ____ Pack per day for ___years

Do you drink alcohol? ☐No ☐rarely ☐ socially ☐____ drinks/ day/ week

Do you have a history of substance abuse? ☐ No ☐Yes. If yes, explain ____________________

FAMILY HISTORY

Member	Alive	Deceased	Age	Health Status or Cause of Death
Mother				
Father				
Brothers #				
Sisters #				

You may elaborate on any family history you think might be significant to your current condition: ______________

____

____

REVIEW OF SYSTEMS (Please check all that apply)

General
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Weight change

Eyes
- ☐ Blurred vision
- ☐ Eye drainage
- ☐ Eye pain
- ☐ Glasses/contacts

Ears/Nose/Throat
- ☐ Hearing problems
- ☐ Nose bleeds
- ☐ Bleeding gums
- ☐ Gum disease
- ☐ Dentures present

Cardiovascular
- ☐ Chest pain
- ☐ Leg Pain w/ walking
- ☐ Dizziness
- ☐ Palpitations
- ☐ Swollen feet/ankles
- ☐ Rapid heart rate
- ☐ Varicose veins

Respiratory
- ☐ Cough
- ☐ Difficulty breathing
- ☐ Chest wall pain
- ☐ Wheezing

Gastrointestinal
- ☐ Indigestion
- ☐ Sour taste in mouth
- ☐ Constipation
- ☐ Heartburn
- ☐ Vomiting blood
- ☐ Bloody stools
- ☐ Dark/tarry stools

Genitourinary
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Frequent bladder infections
- ☐ Heavy periods
- ☐ Frequent urination
- ☐ Urinary incontinence

Musculoskeletal
- ☐ Joint pain
- ☐ Back pain
- ☐ Joint stiffness
- ☐ Arm or leg pain
- ☐ Muscle aches

Skin
- ☐ Recurrent skin infections
- ☐ Acne
- ☐ Fingernail infections
- ☐ Jaundice
- ☐ Rashes

Neurological
- ☐ Difficulty walking
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory loss
- ☐ Numbness
- ☐ Tremor

Hematologic
- ☐ Easy bruising
- ☐ Excessive bleeding
- ☐ Blood transfusions
- ☐ Enlarging lymph nodes

Endocrine
- ☐ Enlarging hands/feet
- ☐ Hair loss
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ New hair growth
- ☐ Infertility

Allergic/Immunologic
- ☐ Allergies
- ☐ Hay fever
- ☐ Frequent colds
- ☐ HIV exposure

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Stress
- ☐ Mood swings
- ☐ Trouble sleeping

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Patient Statement of Financial Responsibility

Thank you for choosing Sohail Shayfer, MD for your healthcare needs. Our staff is committed to enhancing the quality of your care and overall health. This policy statement and release has been designed to inform you of our policies and answer your questions regarding payment of services.

Please be sure that you have read and understand all the information provided in this statement before signing the release. As our patient you signature is both binding and acknowledges your understanding and compliance with our policies.

Payment for Office Visits

For the convenience of our patients we accept cash, Visa, Master Card, traveler's checks and personal checks. Co-payments and deductibles required by individual insurance plans are due at the time the services are rendered. **Returned checks are subject to a $25 return fee.**

Payment for Surgery

Co-payments or deductibles toward surgery are the patient's responsibility and must be paid prior to the date of surgery. If payment is not received prior to surgery it will be postponed. Personal checks will **not** be accepted within two weeks of the surgery date.

Self Pay Patients

We welcome self-paying patients when insurance coverage is not available for our services. Patients without insurance are asked to assume full financial responsibility for the office visit and medical services rendered during the time of service. *If for some reason full payment cannot be made at the time of service please speak with an administrator prior to you office visit to determine if reasonable payment arrangements can be established.*

Delinquent Accounts

Your account will be considered delinquent after 30 days and fee of 2% per month will apply beginning at the first of each month until the account is paid in full. If your account is turned over to a collections agency you will be responsible for the collections fee as well as the account balance. No further services will be rendered until the account is paid and in good standing.

Cancellations and Missed Appointments

In order to be respectful of the medical needs of others please be courteous and call our office at least 24-hours in advance if you are unable to attend or must reschedule an appointment. A fee of $50.00 will be billed to your account if your appointment is missed or if you do not cancel within the appointed time. For your convienience our phone line,
(818) 981-3688 is covered 24-hours a day.

Medical Supplies and X-Rays

Your insurance plan may cover medical supplies and x-rays partially or not at all. We will do our best to abide by your insurance policy and bill them appropriately. However, you will be billed directly if your insurance company denies charges for medical supplies and/or x-rays. Upon request, we will provide you with a cost estimate of all services and supplies

Medicare Patients
We accept Medicare assignment of covered Medicare charges. Patients will be billed for the $100.00 annual deductible or any uncovered charges unless the patient has a supplemental insurance.

Worker's Compensation Patients
We must have prior authorization to treat from either the employer or the insurance carrier agent. Should the employer or carrier subsequently deny a validated worker's compensation service, such charges will be the financial responsibility of the patient.

Personal Injury Patients
Patients with representation must have a signed lien agreement and authorization prior to being seen. It is the patient's responsibility to communicate a change in status to our office if services had previously been billed to a private insurance carrier.

RELEASE

I hereby acknowledge that I have read, understand and agree to comply with all policies outlined herein. I also acknowledge should my account go to collections, I will be charged the collections service fee in addition to all outstanding balances.

______________________________ Date______________________

Signature of Patient/Guarantor

____

Print name

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____

Please print your name here

____

Signature

____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign.

Due to an emergency situation it was not possible to obtain an acknowledgement.

We weren't able to communicate with the patient.

Other *(Please provide specific details)*

____

____

____

______________________________ _______________

Employee signature *Date*

This form does not constitute legal advice and covers only federal, not state, law.

CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient' s Name:

Patient's Date of Birth: Patient's SSN:

Notice to Patient:
By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it.

(To Be Completed by Patient or Patient's Representative)

I, ____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

Patient's Signature or Signature of Patient's Representative ____________ Date ____________

Printed Name of Patient's Representative ____________ Relationship to Patient ____________

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: SOHAIL SHAYFER M.D., INC

Practice Address:
16030 VENTURA BLVD # 100, ENCINO , CA 91436

Phone: 818-981-3688 Fax: 818-981-3588 E-Mail:

NOTICE OF PRIVACY PRACTICES

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

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on *(Insert date)* and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, *(insert name)*. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health 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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $ *(insert fee)* for each page and the staff time charged will be $ *(insert fee)* per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: SOHAIL SHAYFER M.D., INC

Privacy Officer:

Telephone: 818-981-3688 Fax: 818-981-3588

E-Mail: HANDSHOULDER@AOL.COM

Address: 16030 VENTURA BLVD # 100, ENCINO , CA 91436