FOOT & ANKLE
INSTITUTE OF ARIZONA LLC
Where Health & Care Meet

Office: (480) 788-2524
Local Fax: (480) 603-1814
E-Fax: (718) 532-0347
Email: azfoot99@gmail.com
www.MyHouseCallDoc.com

WELCOME TO FOOT & ANKLE INSTITUTE OF ARIZONA!

Kindly fill out and sign the *Podiatry New Patient Form, Insurance Authorization Form, Privacy Practices Acknowledgement Form, and Consent to Treat Form*.

Additionally, please provide us with front and back copies of your primary and secondary health insurance card(s).

You may return the completed forms by any one of the following methods:

Electronically submit your forms to us (fastest way) via link provided to you by email

OR, return the forms by mail to:

Dr. Kamran D. Farahani
6929 N. Hayden Rd.
Suite C4-309
Scottsdale, AZ 85250

OR, fax the forms to: (480) 603-1814 or 1(718) 532-0347

OR, scan the completed forms and **email** them to: azfoot99@gmail.com

Please call our office with any questions or if you need further assistance: (480) 788-2524, Ext. 1.

Thank you and we look forward to the opportunity to care for you!

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PODIATRY NEW PATIENT FORM

Name: _____
First Middle Last

SSN: _____-_____-_____

Address: _____
Number Street City State Zip Code

Telephone: _____ **Age:** _____ **Date of Birth:** _____ **Sex:** Male Female

Marital Status: Single Married Widowed Divorced

Referred by: _____ **How did you hear about us:**_____

In case of an emergency, who should be notified? _____
Full Name (First & Last)

_____ _____
Relation to Patient Telephone

Primary Care Physician (Name, Phone & Fax): _____
Last Visit Date: _____

Primary Insurance: _____ **Member #**_____**Group #**_____

Secondary Insurance: _____ **Member #**_____**Group #**_____

Past Medical History	
Irregular heart beat	Diabetes: Type I Type II
High blood	Dementia/Alzheimer's
Emphysema	HIV
Stroke	Bleeding disorder
Blood clot (DVT)	Congestive heart failure
Heart attack	Thyroid Disease
Heart murmur	Kidney disease or infections
Pulmonary embolism	Cancer
Liver Disease	Anemia (Low Blood Count)
Vascular Disease	Cataracts
Glaucoma	

Past Surgical History	
Surgery:	Date:

Social History:	
Current Alcohol Use: Yes No If Yes→ Drinks per week:	Current Tobacco Use: Yes No If Yes→ Packs/Day Years
Illicit Drugs: Yes No	

RELEASE AND ASSIGNMENT

I, the undersigned, hereby authorize the release of all information necessary to secure the payment of benefits submitted for services rendered by my physician/provider on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my physician/provider to submit claims for benefits for any services rendered without obtaining my signature on each and every claim form, which shall be bound by this signature as though the undersigned had personally signed the particular claim.

I, the undersigned have coverage with the insurance company(s) listed above and assign directly to Foot & Ankle Institute of Arizona LLC, Dr. Kamran D. Farahani, and his/her associate(s) all claim benefits, if any, otherwise payable by me for services rendered. I acknowledge and understand that I am financially and fully responsible for all charges incurred from the services rendered by my physician/provider whether or not paid by the insurance. If any portion of my account balance is not reimbursed by my insurance company for any reason, I agree to cooperate and arrange prompt payment in full. I understand that payment is due upon receipt of my statement. This release shall be in force unless otherwise revoked in writing.

Patient Signature/Responsible Party: _____

Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires that all medical records and other individually identifiable health information used or disclosed by us in any form are kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. As required by HIPAA, we may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations. Treatment means providing, sharing, coordinating, or managing health care information and related services by one or more health care providers or technicians who are taking care of you. Payment means using and disclosing your medical information for payment purposes. Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

We may also create and distribute de-indentified health information by removing all references to individually Identifiable information. We may contact you via mail or telephone to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Doctor:

1. The right to request restrictions on certain uses and disclosures of protected health information to family members, other relatives, friends, or any other person identified by you. We are not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
2. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
3. The rights to receive, inspect, and copy your protected health information. You may be charged a nominal fee for copies as is allowed by Arizona State laws.
4. The right to amend your protected health information.
5. The right to receive an accounting of disclosures of protected health information.
6. The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is in effect as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. The current Notice of Privacy Practices will be held by the doctor at all times at the office or with the doctor during a house call visit. You may request a written copy of a revised Notice of Privacy Practices from the doctor's office.

If you have any questions or feel that your privacy rights have been violated, you have the right to submit a written complaint with our office or with the U.S. Department of Health & Human services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate in any way if you choose to file a complaint.

"NOTICE OF PRIVACY PRACTICES" ACKNOWLEDGEMENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have been provided with a copy of Dr. Farahani's Notice of Privacy Practices Form.

Patient Signature/Responsible Party: _____
Date: _____

CONSENT FOR TREATMENT

Patient Name (First, Middle, Last)_____

Consent for treatment:
I recognize that I need medical services. I voluntarily consent to treatment by the medical staff of Foot & Ankle Institute of Arizona, LLC. as deemed necessary in their judgment. I am aware that the practice of podiatric medicine and surgery is not an exact science and that no guarantees have been made to me regarding the results of examinations, treatments or tests. I understand that if major diagnostic studies, treatment procedures such as surgery are required, I will be asked to give specific consent for that.

Use of Medical Information:
I understand consistent with Arizona and federal law, Foot & Ankle Institute of Arizona, LLC will share all medical information as necessary for continuation of care and with any other institution or person as allowed by law. As an example, I understand that Foot & Ankle Institute of Arizona, LLC does not have an in-house lab and uses an out-sourced medical laboratory and my lab work and personal information is shared to accomplish testing I may desire. Privacy and confidentiality of persona health information is important at Foot & Ankle Institute of Arizona, LLC. There are policies in place to insure that your personal health information is available only to authorized persons who need access to this information to provide medical care. No patient information leaves the office either electronically, by fax, or paper records without specific authorization by the patient.

Release of Information:
I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I authorize payment of medical benefits to Foot & Ankle Institute of Arizona, LLC.

I have read and fully understand to my satisfaction, this entire document consisting of consent to treat, and use medical information. I may be asked to update my signatures and personal information annually or not less than once ever three years. I am capable of signing this document on my own.

Patient Signature/Responsible Party: _____ Date: _____

----------**MEDICAL POWER OF ATTORNEY**----------
I am the **Legal Medical Power of Attorney** that must be informed of all medical decisions and visits: (Please print information below and sign on signature line)

Name: _____ Phone: _____

Address: _____

Power of Attorney Signature:_____ Date:_____