

DR. ARA KALLIBJIAN
WELCOME TO OUR OFFICE

PLEASE PRINT AND COMPLETE THE FOLLOWING. THANK YOU.

Today's date:

PATIENT INFORMATION

Patient's last name: _____ First: _____ Middle: _____ Marital status (circle one)
 Single / Married / Divorced / Widowed

Name of Spouse/Guardian: _____ Relationship: _____

Birth date: ____/____/____ Age: _____ Sex: M F Social Security #: _____ Pharmacy:
 Location: _____

Primary Language: _____ Race: _____ Ethnicity: _____

Home address: _____ Home phone: _____ Cellphone : _____
 Can we leave message: Y N ()

City: _____ State: _____ ZIP Code: _____ Email Address: _____

Occupation: _____ Employer: _____ Employer Address: _____ Employer Phone: _____
 ()

Referred to Dr. Kallibjian by: Dr. Insurance Plan Hospital/ER

Family/Friend (name) Internet/Google Yellow Pages Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: _____ Birth date: ____/____/____ Address (if different): _____ Home phone : _____
 ()

Primary Insurance: _____ Secondary Insurance: _____ Patient's relationship to subscriber: _____

Name of Family Physician: _____ Phone # of Physician: _____ Last Date Seen: _____

Emergency Contact: _____ Phone Number: () _____ Relationship to Patient: _____

List any medications taken regularly:

My chief foot complaint is: _____ Is it work related? _____

This condition (s) has existed for: _____ Days _____ Weeks _____ Months _____ Years

Are you allergic or sensitive to: Please check all that apply:

___ Penicillin ___ Iodine ___ Adhesive Tape
 ___ Sulfa ___ Foods _____ ___ Latex
 ___ Novocaine/Lidocaine ___ Other (Please Explain)

I hereby give Dr. Ara Kallibjian permission to examine and treat my podiatric problems.

Patient/Guardian signature

Today's Date

Acceptance of Insurance Assignment and Financial Policies

Please initial each line showing you agree to abide with the following:

- _____ I authorize Ara Kallibjian, D.P.M. and its agents to furnish my insurance companies with all necessary information concerning diagnosis and treatment for myself or dependents under compliance of the Health Insurance Portability and Privacy Act of 1996 (HIPAA).
- _____ I assign the medical and/or surgical benefits that my dependents and I are entitled to under my health insurance plan to Ara Kallibjian, D.P.M.
- _____ I agree to pay all balances accrued with Ara Kallibjian, D.P.M. for services rendered as limited by my insurance plan.
- _____ I understand I am responsible for all co-payments, deductibles, coinsurance and charges for non-covered services which must be paid prior to services being rendered.
- _____ I understand some medical/surgical and/or durable medical equipment services will require a pre-paid deposit. All deposits will be applied to any outstanding charges for those services rendered. Any excess funds remaining after receiving insurance remittance will be applied to outstanding balances and/or refunded promptly.
- _____ I understand that if my insurance requires a referral to a specialist, I am responsible.
- _____ Ara Kallibjian, D.P.M. does not generally arrange payment plans. In situations of extreme financial hardship, discuss your situation with the office manager.
- _____ I understand when an outstanding balance is sent to collections, a collection fee is added as follows:
- | | |
|--------------------------|----------------|
| Balance of \$0-\$99..... | \$25 |
| \$100-\$199..... | \$50 |
| \$200-\$299..... | \$75 |
| \$300 and above..... | 30% of balance |
- _____ Balance not paid after 150 days may be referred to an attorney for collection. All legal and collection fees will be the guarantor's responsibility.
- _____ I understand a \$40.00 fee will be charged for a returned check.
- _____ I understand that a \$65.00 fee may be charged for appointments that are cancelled or broken without a 24 hour advance notice.

- _____ For **Medicare** patients, I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I assign benefits payable to the physician or authorize the physician to submit a claim to Medicare for payment.
- _____ For **minors**, in the case of **divorced** parents, payment is expected from the person signing this document and will be considered the guarantor for all payments for any services provided. Ara Kallibjian, D.P.M. will not recognize any divorce decrees regarding reimbursement for medical services for any minor child of divorced parents.
- _____ **College students** expecting payment through health insurance under their parent's name will not be treated without written permission from parent or guardian. Original signature or fax is allowable. The student being treated gives permission to Ara Kallibjian, D.P.M. to contact parents regarding his or her health conditions per HIPAA requirements. Parents agree to be responsible for all charges unless other arrangements are made in advance.

Signature of Patient/Responsible Party

Date

Rev.4/2020

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operation.

I, _____, understand that as part of my health care, DR. ARA KALLIBJIAN originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a copy of the **NOTICE OF PRIVACY PRACTICES** and have read or had the opportunity to read if I so chose, that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that DR. ARA KALLIBJIAN is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoke this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that DR ARA KALLIBJIAN reserves the right to change their notice and practice and prior to implementation, in accordance with section 164.520 of the Code of Federal Regulations. Should DR. ARA KALLIBJIAN change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept/decline the terms of this consent.

_____ Patient's Signature _____ Today's Date

OFFICE USE ONLY

- [] Consent received by _____ on _____.
- [] Consent refused by patient, and treatment refused as permitted.
- [] Consent added to the patient's medical record on _____.

Name: _____

Date: _____

HEALTH QUESTIONNAIRE: Please circle or list conditions in each body system

Constitutional: anxiety * fever * chills * weight gain * weight loss * appetite change * fatigue/exhaustion

Cardiovascular: rapid heartbeat * palpitations * sweating * ankle swelling * cold feet high/low blood pressure * color changes in hand/feet * pacemaker * murmur * varicose veins * blood clots * leg cramps * poor healing

Endocrine: cold/heat intolerance * high/low blood sugar * weight gain/loss * hair loss * increased thirst * increased urination * delayed wound healing * dry skin * fatigue

Ears, Nose, Mouth, Throat (ENMT): hearing loss * ringing in ears * dry mouth * nose bleeds * blisters/white patches in mouth * sore throat

Eyes: blurry * vision loss * glaucoma * dry eyes

Gastrointestinal: nausea * vomiting * diarrhea * constipation * abdominal pain * blood in stool * heartburn* difficulty swallowing * yellowing of skin * stomach ulcers

Genitourinary: blood in urine * brown colored urine * pain during urination * infection * sexually transmitted disease * kidney failure * kidney stones (past/recent)

Immunologic/Allergic: arthritic flare up * gouty attack * environmental allergies * Hepatitis B carrier * HIV positive* prone to infection

Integumentary: athletes foot * blisters * dermatitis * dry/scaly skin * eczema * excess scar tissue * hair loss* rash * ulcers * ingrown nails * thick nails * discolored nails * corns/callus * itching of skin * warts

Lymphatic/Hematologic: swelling legs/ankles * bleeding problem * difficult to stop bleeding * anemia * bruising * enlarged lymph node * calf pain

MUSCULOSKELETAL: morning stiffness * joint redness/warmth * arthritis * weakness * muscle wasting * ankle sprain* foot/ankle/leg fractures * foot/leg cramps * difficulty walking * neck/low back/hip/ankle/foot pain * arch/heel pain * bunions* hammertoes

Neurological: headache * dizziness * balance problem * coordination problem * tremors * uncontrolled movements * speech problem * numbness/tingling/burning * increased sensitivity to touch * paralysis

Psychological: depression * disorientation * forgetfulness * memory loss

Respiratory/Pulmonary: cough/cold/flu symptoms * shortness of breath * wheezing * asthma * asthma attack * chest tightness * Tuberculosis exposure (recent)

Do you have (or have had) any of the following: (Please circle)

- | | | | |
|-------------------------|----------------------------|----------------------|-----------------------|
| Diabetes | High blood pressure | Heart Disease | Kidney Disease |
| Asthma | Gout | Stroke | Cancer _____ |
| Anemia | Liver Disease | Hepatitis | Stomach ulcer |
| Arthritis | Blood Disease/Clots | Alcohol Use | Tobacco Use |
| On Blood Thinner | Substance Abuse | Other: _____ | |

*******PLEASE LIST ANY SIGNIFICANT FAMILY MEDICAL CONDITIONS** _____

*******I HAVE REVIEWED THE ABOVE. PLEASE SIGN HERE :** _____ **(Rev. 4/2020)**