

OUR CANCELLATION / NO-SHOW POLICY

DUE TO THE INCREASING NUMBER OF NO-SHOW AND SAME DAY CANCELLATIONS OF APPOINTMENTS, WE ARE INSTITTUING A NEW POLICY, EFFECTIVE IMMEDIATELY.

THE POLICY IS AS FOLLOWS:

1. Cancelled appointments within 24 hours of appointment time - **\$25.00 fee**
2. No show for appointment time - **\$50.00 fee**
3. Surgery cancellation within five days of schedule surgery time – **\$750.00 fee**
4. Any forms or letters will charge accordingly.

OUR STAFF APPRECIATES YOUR UNDERSTANDING

THANK YOU,

I have read and agree to the above policy.



Patient's Signature

Patient Print

Date

Your payment information

We Accept



Card Details

Card Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Expiration Date

		/		
--	--	---	--	--

CCV

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PATIENT INFORMATION

First: _____ M.I. _____ Last: _____

Preferred Name: _____ Sex: M F DOB: _____

Mobile Phone: _____ E-mail: _____

Home Phone: _____ Work Phone: _____

Preferred method of communication: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Relationship: _____

Phone # _____ Alternative# _____

Patient relationship to Guarantor: Self Spouse Child Other

Guarantor Name: _____

Guarantor Address: _____

Guarantor City: _____ State: _____ Zip Code: _____

Guarantor DOB: _____ M F Social Security #: _____

Guarantor Phone: _____ Secondary Phone: _____

Patient's Ethnicity: _____ Language: _____ Patient's Race: _____

Primary Doctor: _____ Last Visit: Month _____ Year _____

How did you hear about us? Google Yelp Website Insurance

Referred by: _____

Pharmacy: _____ Phone Number: _____

Prescription History

In order to have the most current prescription information, we need to request the information electronically. Do we have permission to do so? Yes No

Signature: _____ Date: _____

Primary Doctor: _____ Phone No: _____ Date of last exam: _____

Describe the condition that brought you to this office: _____

If auto accident, date of accident _____ Previous care for this condition? Yes No

Dr. _____ Date: _____

HEIGHT: _____ **WEIGHT:** _____ **HAVE YOU RECEIVED THE FLU SHOT THIS YEAR?** YES NO

MEDICAL: (Please check any of the following if it pertains to you)

- | | | | |
|---|---|---------------------------------------|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Scar Former | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Seizures | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hypercholesterol |
| <input type="checkbox"/> Human Immunodeficiency Virus (HIV) | <input type="checkbox"/> Circulation Disorder | <input type="checkbox"/> ADHD | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke/TIA's | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hypothyroidism |
| | <input type="checkbox"/> Bipolar | <input type="checkbox"/> Hepatitis | |

ALLERGIES:

None Penicillin Aspirin Codeine Novocain Iodine Latex

Other: _____

MEDICATIONS: (Please include Aspirin, Tylenol, Vitamins and Birth Control Pills) _____ See attached list

1 _____ 2 _____ 3 _____ 4 _____

5 _____ 6 _____ 7 _____ 8 _____

PREVIOUS SURGERIES AND HOSPITALIZATIONS:

1 _____ 2 _____ 3 _____ 4 _____

Please check all the apply

- | | | | | | |
|-------------------------|--|-----------------------------------|--|--|--------------------------------------|
| FAMILY HISTORY } | <input type="checkbox"/> MATERNAL | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> PATERNAL | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> Other _____ |

SOCIAL HISTORY:

- | | | | | |
|----------------------|--------------------------------|-------------------------------------|-----------------------------------|--------------------------------|
| Alcohol Intake | <input type="checkbox"/> None | <input type="checkbox"/> Occasional | <input type="checkbox"/> Moderate | <input type="checkbox"/> Heavy |
| Caffeine Intake | <input type="checkbox"/> None | <input type="checkbox"/> Occasional | <input type="checkbox"/> Moderate | <input type="checkbox"/> Heavy |
| Illicit Drugs | <input type="checkbox"/> None | <input type="checkbox"/> Occasional | <input type="checkbox"/> Moderate | <input type="checkbox"/> Heavy |
| Exercise Level | <input type="checkbox"/> None | <input type="checkbox"/> Occasional | <input type="checkbox"/> Moderate | <input type="checkbox"/> Heavy |
| Smoking Status | <input type="checkbox"/> Never | <input type="checkbox"/> Former | <input type="checkbox"/> Current | |
| General Stress Level | <input type="checkbox"/> Low | <input type="checkbox"/> Medium | <input type="checkbox"/> High | |

PODIATRIC HISTORY:

- | | |
|--|---|
| <input type="checkbox"/> Flat Feet | <input type="checkbox"/> Pain or fatigue in feet & legs with activity |
| <input type="checkbox"/> Heel or arch pain (Child or Adult) | <input type="checkbox"/> Numbness and tingling in feet and toes |
| <input type="checkbox"/> Pain in feet getting out of bed | <input type="checkbox"/> Bunions (prominent foot bones) |
| <input type="checkbox"/> Crooked toes (hammertoes) | <input type="checkbox"/> Ankle swelling & stiffness |
| <input type="checkbox"/> Ankle instability (easy twisting injuries) | <input type="checkbox"/> Leg pain (shin splints) |
| <input type="checkbox"/> Growing pains | <input type="checkbox"/> Difficulty walking/running |
| <input type="checkbox"/> Poor coordination with sports | <input type="checkbox"/> In-toe or out-toe gait |
| <input type="checkbox"/> Abnormal foot posture (clubfoot, metadductus) | <input type="checkbox"/> Achilles' tendon pain |

Other problems with your feet/legs: _____

South Florida Lower Extremity Center
Dr. Nooshin Zolfaghari D.P.M and Dr. Igor Zilberman D.P.M.
Foot and Ankle Surgeon
2699 Stirling Road Suite A-301 / 302
Office (954) 278-3890 / Fax (954) 251-1470

ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS: I _____,
Do hereby IRREVOCABLY ASSIGN to the above-named medical provider, any right or benefits under my policy of insurance with _____, for any service and/or charges provided by the above medical provider. Pursuant to this ASSIGNMENT OF BENEFITS, you are hereby directed to mail any and all checks directly and solely payable to the above named medical provider at the address listed on the HCFA-1500A form in box 33. As part of this ASSIGNMENT OF BENEFITS, I hereby instruct the insurance carrier that in the event the medical benefits are disputed for any reason, including medical reasonableness and/or necessity, that the amount of benefits claimed by **South Florida Lower Extremity Center** is to be set aside and not disbursed until the dispute is resolved.

IN WITNESS WHEREOFF the undersigned has hereunto set his/her hand, this ____ day of _____, 20____.

Patient's Signature

Patient's Name (please print)

South Florida Lower Extremity Center
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Foot and Ankle Surgeon
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**ACKNOWLEDGEMENT OF RECEIPTS OF PRIVACY NOTICE
AND CONSENT TO USE HEALTH INFORMATION**
(Read before signing the Acknowledgement and Consent)

This Acknowledgement of notice and consent authorizes **South Florida Lower Extremity Center** to use health information about you for treatment, payment, and health care operations purposes.

NOTICE OF PRIVACY PRACTICES: **South Florida Lower Extremity Center** has a Notice of Privacy Practices which describes how we may use your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

AMENDMENTS: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer
Mail: 2699 Stirling Road Suite A301/302 Hollywood, FL 33012
Tel: (954) 278-3890 / Fax: (954) 251-1470

Acknowledgement and Consent

I have received the Notice of Privacy Practices for **South Florida Lower Extremity Center** is authorized to use health information about (please print patient's name) _____ for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

Signature of Patient

Date

Account #

Personal representative information (if applicable):

Name of Personal Representative

Relationship to Patient

IDENTITY OF RECIPIENTS: Provide the name or other specific identification of the person(s) or class of persons to whom the covered entity may disclose the covered information:

Permission to Leave Message: YES NO

___ Daytime phone / Ph# _____

___ On my home answering machine / Ph# _____

___ On my voicemail / Ph# _____

___ With my designated and authorized person(s) named below:



MEDIA RELEASE FORM

I, _____, grant permission to South Florida Lower Extremity Center to use my image (photographs and/or video) for use in media publications including:

- Facebook Instagram Brochures Email Blasts (Mailchimp)
- Other: _____

I hereby waive any rights to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, weather that use is known to me or unknown.

Please **initial** the paragraph below which is applicable to your present situation:

_____ I am 21 years of age or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

_____ I am the parent or legal guardian of the below named child. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Patient Name: _____ Date: _____

Name: (Please print): _____

Address: _____

Signature of parent or legal guardian: _____
(if under 21 years old of age)