AZAR Foot & Ankle Specialist

9675 Monte Vista Ave, Suite E
Montclair, CA 91763
T: 213-537-2927
F: 909-385-1690

Patient Information

Name: _____ Cell #: _____

Address: _____ City: _____ Zip Code : _____

DOB: _____ Age: _____ Sex: M / F Marital Status: S M W D

Occupation: _____ SS: _____

Employer: _____ Address: _____

Work Phone: _____ Home Phone: _____ E-mail: _____

Pharmacy: _____ Location: _____ Pharmacy #: _____

Primary Care Doctor: _____ PCP Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Medical Insurance

Company Name: _____ Policy Holder's Name: _____

Member ID: _____ Group: _____

Other Insurance?: _____

Medicare: Yes☐ No☐ Medi-Cal: Yes☐ No☐ **WE WOULD LIKE A COPY YOUR INSURANCE CARDS**

Whom may we thank for referring you to our office?: _____

I hereby give permission to Dr. Edward Azar, DPM and his associates or assistants, to administer treatment as may be deemed necessary in diagnosis and treatment of my foot condition.

I request that payment of authorized medical insurance or Medicare benefits be made in my name directly to Edward Azar, D.P.M. for the services they have given me. I authorize any holder of medical information about me to disclose to Medicare or any other insurance company or its agents, any information necessary to determine these medical benefits. I acknowledge the Notice of Privacy Practices and HIPAA compliance of this office, which describes the use, restrictions and disclosure of my protected health information.

- I understand and accept that I am ultimately responsible for payment and for all medical services not covered.
- I certify that this information is true and correct to the best of my knowledge and belief.

_____ _____

Date Signature of patient or Legal Guardian

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Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that they provided me with a copy of the Notice of Privacy Practices and that I read it (or had the opportunity to read if I choose to do so) and understood the notice.

_____ _____

Patient Name(Please Print) Date

_____ Legal Guardian or Authorized Representative (if applicable)

Signature:

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MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made on my behalf to **Dr. Edward S. Azar DPM** at **Azar foot & Ankle Specialist** for any services furnished me by the listed Physician/Supplier. I authorize any holder of Medical information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services. I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the below named Medigap Insurer any information needed to determine benefits payable for services from this provider.

I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Block 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare Carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare Carrier.

Patient's Name:_____ Patient Date of Birth: _____

Signature:

Medicare Number: _____ Medigap number:_____

Provider's Name: Edward Shibli Azar DPM

Provider's Address: 9675 Monte Vista Ave, Suite E; Montclair CA, 91763

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____to disclose my protected health information as described below. I understand that this authorization is voluntary. I understand that the 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 law. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation. I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Patient name: _____ **Date of birth:** _____

Persons/organizations to receive the information: _____

The specific information to be released/disclosed is specified below:

____Complete Medical Record

Or specify one or more of the following:

____Operative Reports _____ X-rays ____Progress Notes

____ Billing and Claim Records _____ Laboratory ____ (Other_____)

This information is to be used/disclosed for the following purposes(s) only:

_____

(no purpose need be stated if the request is made by the patient and the patient does not wish to state the purpose).

This authorization will expire on _____ (state date or event).

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have crossed it out, and initialed it. • **Yes** • **No** _____ **Initials**

Signature of patient or patient's representative _____ **Date** _____
(Form MUST be completed before signing.)

Printed name of patient's representative (if applicable):_____
Relationship to the patient (if applicable):_____
* YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT*

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MEDIA CONSENT FORM / AUTHORIZATION FOR PUBLICATION I hereby give my consent for photography, filming, videotaping and/or audio recording or other means of capturing my image or voice and/or being quoted in the media or printed materials (including social media websites)

Check one of the following:
I am: Patient _____ (or) Patient's surrogate (legal representative) _____,Staff ____, Volunteer____, Visitor ____, Other (describe) _____.

I APPROVE THIS CONSENT YES ☐ NO ☐

Name: _____ Date of Birth: _____
Address: _____
City, State, ZIP: _____ Phone: _____
Email: _____

I hereby authorize Azar Foot & Ankle Specialist and its affiliates and agents to take photographs or produce videotapes, audiotapes, electronic files, or other types of media productions that capture my name, voice and/or image, to be released to members of the social media or media, for the purpose of:

- **News media (online, print and/or broadcast)**
- **Websites and social media**
- **Publications and/or promotional materials**
- **Medical and/or educational training**
- **Closed circuit television programs**
- **Any other lawful purpose**
- **Advertisements**

The information to be disclosed includes: Photographic images of me Information about my medical condition and/or prognosis Video or audio of me and/or my voice Information about date(s), time(s) and type(s) of treatment Images from records such as scans and/or X-rays received, Other _____ .

I further understand that this authorization is voluntary, without compensation, and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or receive payment from my insurance company. It will also not affect my eligibility for benefits. I understand by signing this form I represent and warrant that I have authority to sign this document, authorize the use or disclosure of protected health information and declare there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. I understand that once my information is disclosed, it may be re-disclosed by third parties on other media.

This authorization shall remain in effect until revoked. You may provide such notice by sending your written request to **Azar Foot & Ankle Specialist, 9675 Monte Vista Suite E, Montclair CA 91763**

Signature of patient/visitor or patient's/visitor's legal representative: _____

Date _____

(If signing as a representative, please indicate your relationship to Printed name of patient/visitor or representative the patient/visitor: Parent Guardian Power of attorney) _____

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HIPAA Consent

I understand that under the Portability and Insurance Liability Act of 1996 (HIPAA). I have certain privacy rights regarding my protected health information. I understand that this information can and will be used to:

carry out a plan and direct my treatment and follow up among the multiple healthcare providers that may be involved in that treatment directly and indirectly.

Obtain payment from third party payers.

Perform normal health care operations, such as quality assessments and medical certifications.

You have informed me of your notice of privacy practices that contains a more complete description of the uses and disclosures of my health information. I have been given the opportunity to review this notice of privacy practices before signing this contract. I understand that this organization has the right to change its notice of privacy practices from time to time and that I may contact the organization at any time at the address below to obtain an updated copy of the notice of privacy practices.

I understand that I may request in writing to restrict how my private instruction is used or disclosed to carry out treatment payment health care operations. I also understand that you are not required to accept the requested restrictions, but if you do, you are required to comply with those instructions.

I understand that I may revoke this consent in writing at any time, except to the extent that I have taken action relying on this consent.

Patient or legal guardian's name:_____

Signature: _____ Date:_____

Witness/ Interpreter: _____ Date/ Time: _____

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Confidential Record from the Office

Patient Data/ Emergency Numbers	**Date**	**New ☐ Update☐**

Name: **MI:** **Last Name:** **Occupation:**

SS: **Sex:** **Age:** **DOB:** **Shoe Size**

In case of emergency:
Name:_____
Phone #:_____

Preferred Pharmacy
Name:_____
Phone #: _____

Historial médico del paciente

Have you had/ been treated for:
☐Lower back pain ☐Childhood foot problems ☐Broken foot bone(s) ☐Hammertoes ☐Numbness ☐Leg or foot Ulcers ☐Ankle injury ☐Knee pain ☐High arch feet ☐Bunions ☐Rash ☐Ingrown toenails ☐Neuroma ☐Arch pain ☐Heel pain ☐Flat feet ☐Corns/ calluses ☐warts ☐Athlete's foot ☐None of these

¿What percentage of you hours awake are you on your feet? (Check one)
☐**20%** ☐**40%** ☐ **60%** ☐ **80%** ☐ **100%**

List the sport/type of dance you are active in:_____

¿Do your feet hurt at night? Yes☐No☐
¿Do you have difficulty walking?Yes☐No☐
¿Do you get leg cramps?Yes☐No☐
¿Any pain in calves or buttocks when walking?Yes☐No☐
¿Is the pain relieved by rest?Yes☐No☐

¿Do you have or have you ever been treated for:
☐Stroke ☐Phlebitis ☐Anemia ☐Hepatitis ☐Asthma ☐Arthritis ☐Epilepsy ☐Broken Bone ☐Scarlet fever ☐Glaucoma ☐Heart attack ☐Poor circulation ☐Diabetes ☐Liver disease ☐Lung disease ☐Gout ☐Nerve Disorder ☐Osteoporosis ☐Rheumatic fever ☐Cancer ☐High blood pressure ☐A Heart condition ☐Vascular disease ☐Kidney disease ☐Tuberculosis ☐Lyme's disease ☐Psychiatric disorder ☐Keloid/Thick scarring ☐ Stomach ulcer ☐None of this.

¿Do you have vascular grafts? (If yes explain below) Yes☐No☐
¿Do you have joint implants? (If yes explain below) Yes☐No☐
¿Do you have replacement heart valves? Yes☐No☐
¿Are you now under active chemotherapy? Yes☐No☐
¿Have you ever had any other serious illness? (List below) Yes☐No☐
¿Have you ever been hospitalized or been under medical care for over 24 hours? Yes☐No☐
¿Have you had any surgery? Yes☐No☐

Continue next page

List the relationship to you of family members who have had
Diabetes:_____ Arthritis:_____
Stroke:_____ Cancer:_____
Foot problems: _____
Heart Attack:_____
High Blood Pressure_____
Birth Defects:: _____

# of childbirths: ___¿Are you currently pregnant? Yes☐No☐

¿Are you slow to heal? Yes☐No☐

¿Any abdominal bruising, pleading or scarring?Yes☐No☐

¿Are you taking insulin? Yes☐No☐

¿Are you currently taking any medications? Yes☐No☐

¿Medication for what problem? ¿For how long?

_____ _____ _____
_____ _____ _____
_____ _____ _____

¿Do you smoke now? Yes☐No☐ Packs /day _____ Yrs: _____
¿Did you ever smoke?Yes☐No☐Packs/day:____ Yrs:_____
If you quit, When did you do so?_____

¿Alcoholic beverages? (Check one)
☐None ☐Rarely ☐Moderately ☐Daily ☐Quit
¿Recreational drugs? (Check one)
☐None ☐Rarely ☐Moderately ☐Daily ☐Quit

Allergies: Is there a history of skin reaction or other outward reaction or sickness following injection, oral or topical administration
Penicillin: _____
Other antibiotics (list below):_____
Morphine:_____
Codeíne: _____
Demerol: _____
Other narcotics (list below): _____
Novocaíne: _____
Other anesthetics (lista abajo) : _____
Aspirin: _____

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Had surgery for:	Date of surgery:	w/ complications of:
_____	_____	_____
_____	_____	_____
_____	_____	_____

¿Anything else that you want to tell the doctor?Yesi□No□

Illnesess/Explanations:_____

_____

_____

_____

Empirin, Tylenol (if yes, circle) : _____
Advil, Aleve or Motrin (circle : _____
Other pain remedies(list below): _____
Sulfa drugs: _____
Adhesive tape: _____
Shrimp,Iodine or merthiolate: _____
Any other drugs or medications : _____
Allergic to/Reaction:_____

_____

_____

_____

Other problems you would like to tell the doctor about?

_____

_____

_____

_____

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Podiatric Medical History

Patient Name: _____ **DOB** _____

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, hip & lower back complaint)?_____

Patient/Guardian Signature_____**Date**_____

Have you ever been to a Podiatrist before? □ **NO** □ **YES**; Date of last visit: _____Reason: _____

Are you Diabetic? □**NO** □ **YES:** How many years _____ Last A1C: _____ Shoe size (if applicable):_____

Change of Primary doctor? □ **NO** □**YES:** Height:_____ Weight: _____

Circle all that applies: Do you or anyone in your family members have a history of Diabetes, Arthritis or poor circulation? □**NO** □ **YES:** Indicate who: _____

Do you/did you ever Smoke: □**NO** □ **YES:** How many years _____. On Dialysis: □**NO** □ **YES**: How many years _____

Athletic activities in which you participate (please list and indicate frequency):

_____

Change of Medication: □ **NO** □**YES**: _____

Please indicate which foot problems you now have or have had in the past.

□ Cramps or Numbness in feet or legs while sleeping, while walking, while sitting, during the Day.
□ Athlete's Foot or Itchy Feet
□ Fungal Nails
□ Corns & Calluses
□ Bunion & Hammer toe
□ Flat Feet Foot or Arch pain
□ Heel Pain
□ Ankle Pain
□ Ingrown Toenails
□ Plantar Warts
□ Swelling in Ankles Feet
□ Tired Feet
□ Wound/Ulcer
□ Other_____

OFFICE USE ONLY

B/P:_____ **TEMP:** _____ **Last PCP visit:** _____

CPT'S APPROVED FOR TODAY'S VISITS AUTH #:_____

_____ _____ _____ _____

Insurance:	Deductibles:	Coinsurance:	Copay:

OFFICE VISITS / NURSE VISIT/ TRAINING

- ☐ 99203 - OV NEW PT 30 MINS
- ☐ 99204 - OV NEW PT 45 MINS
- ☐ 99205 - OV NEW PT 60 MINS
- ☐ 99213 - OV EST PT 15 MINS
- ☐ 99214 - OV EST PT 25 MINS
- ☐ 99215 - OV EST PT 40 MINS
- ☐ 99211 - OFFICE VISIT with NURSE
- ☐ 97032 - ULTRASOUND
- ☐ S0395 - CASTING INSERTS/SCANS
- ☐ 97760 - ORTHOTICS (MANAGEMENT TRAINING)

ULCER DEBRIDEMENT

- ☐ 97602 - Bandage Change
- ☐ 97505 - Wound Vac change
- ☐ 97597 - OPEN WOUND 1ST 20 SQ CM/ Hydro
- ☐ 11042 - SUBCUTANEOUS TISSUE DEBRIDEMENT
- ☐ 11043 - MUSCLE &/OR FASCIA DEBRIDEMENT
- ☐ 11044 - BONE DEBRIDEMENT 20 SQ CM
- ☐ 20220 - Bone Biopsy

MODIFIER

- ☐ 11056/57 - CORN/CALLUS 2-4/ 4+ LESION
- ☐ 11720 - DEBRIDEMENT OF NAIL ONE TO FIVE
- ☐ G0127- TRIMMING OF DYSTROPHIC NAIL

INGROWN NAIL & BIOPSY

- ☐ 11730 - AVULSION OF NAIL PLATE SINGLE
- ☐ 11732 - AVULSION OF NAIL PLATE EACH ADDITIONAL NAIL PLATE
- ☐ 11750 - EXCISION OF NAIL AND NAIL MATRIX
- ☐ 11755 - BIOPSY OF NAIL UNIT
- ☐ 11102 - BIOPSY OF SKIN SINGLE LESION (SHAVE, SCOOP, SAUCERIZE, CURETTE)
- ☐ 17110 - WART Destruction of Benign Lesion
- ☐ 11200 - SKIN TAG REMOVAL

CAST

- ☐ 29425 - APPLICATION OF SHORT LEG CAST
- ☐ 29445 - APP OF RIGID TOTAL CONTACT LEG CAST
- ☐ 29515 - POSTERIOR SPLINT
- ☐ Q4038 - CAST SUPPLIES, SHORT LEG CAST
- ☐ 29700 - CAST REMOVAL

ORTHOTIC

- ☐ L3000- FOOT INSERTS CUSTOM

TAPING

- ☐ 29540 - STRAPPING: ANKLE AND/OR FOOT
- ☐ 29580 - STRAPPING: UNNA BOOT

INJECTION

- ☐ 20605 - Injection Ankle
- ☐ 64455 - Injection Metatarsal with steroid
- ☐ 20550 - Inj Heel: SINGLE TENDON/SHEATH/LIG
- ☐ J1100 - DEXAMETHASONE
- ☐ J3301 - TRIAMCINOLONE
- ☐ 76942 Ultrasonic Guidance Procedures

GRAFTS

- ☐ 15275 - SKIN SUBSTITUTE GRAFT APPLICATION
- ☐ Q4173 - PALINGEN OR XPLUS (4X4 16 UNITS)
- ☐ Q4158 - KERECIS

MA INITIALS
:_____

DME

- ☐ L1940 - AFO Arizona Custom Brace
  - ☐ L2330 - Additional - LE MOLDED
  - ☐ L2820 - Additional - SOFT INTERFACE
- ☐ L1960 - AFO Drop foot custom, no hinge
  - ☐ L2820 - Additional - SOFT INTERFACE
- ☐ L1970 - AFO Richie Brace Custom with hinge
- ☐ L2220 - Additional - Hinge ASSISTANT for AFO
- ☐ L3030 - Additional - AFO with removal insert
- ☐ L4361 - CAM WALKING BOOT
- ☐ L4397 - Night Splint STATIC OR DYNAMIC AFO
- ☐ L3260 - POST OP SHOE [IEHP]
- ☐ L3310 - EvenUp [IEHP]
- ☐ L1906 - Ankle Sleeve [IEHP]
- ☐ L1902 - Ankle Brace (laces)

DM SHOES

- ☐ A5500 - DM SHOES / NON DM - L3224/5♀ (2)
- ☐ A5513 - DM INSERT (6)
- ☐ L5000 - DM insert with filler
- ☐ L3031 - SHANK

Patient will need

- ☐ LFT
- ☐ X-ray b/l Foot
- ☐ X-ray Ankle Rt or LT
- ☐ MRI Foot Rt or LT
- ☐ MRI Ankle Rt or LT
- ☐ Circulation: VIP, Radnet, Provascular,other
- ☐ Topical Antifungal Cream
- ☐ Topical AntiPain Cream
- ☐ Pain Medication
- ☐ Lidocaine Patches
- ☐ Antibiotics
- ☐ Dalavance, Nuzyra
- ☐ Santyl, Wound Vac, Grafts
- ☐ Patient wants Surgery
- ☐ ABI (93922, 93923)

Work Status: OFF WORK, FULL DUTY OR LIGHT DUTY
:_____

FOLLOW UP APPOINTMENT:_____

- ☐ RIOS SOUTH PC FOLLOW UP 90 DAYS
- ☐ PC FOLLOW UP 60-90 DAYS

Notes_____
_____
_____