PAYAM VAHEDIFAR, M.D.

PAIN MANAGEMENT

818-986-0200

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name _____ First Name _____ Middle _____

Street Address _____ City _____ State _____ Zip _____

Home Phone (___)_____ Cell Phone (___)_____ SSN: _____

Date of Birth _____ Age _____ Sex: _____ Marital Status: _____

E-mail Address: _____ Who referred you? _____

EMPLOYER INFORMATION

Patient's Occupation _____

Address _____ Phone (____)_____

Circle One: Student Not Student If Student, Name of School _____

SPOUSE INFORMATION

Spouse's Name _____

Date of Birth _____ SSN: _____

EMERGNECY CONTACT INFORMATION

Name _____ Relationship to patient _____

Address _____ Phone (____)_____

REPSPONSIBILITY PARTY INFORMATION - MINORS

(*this is the person that brings the minor to their first appointment*)

Responsible Party _____ Date of Birth _____ SSN _____

Address _____ Phone (____) _____

Relationship to Patient: _____

AUTHORIZATION FOR MEDICAL TREATMENT

I, _____ hereby authorize Payam Vahedifar to perform evaluation and treatment of my orthopedic condition(s). I further authorize Payam Vahedifar to perform additional procedures, as he may deem immediately necessary on an emergent basis. I understand that elective surgical procedures will be consented separately. I have the right to refuse specific services at any time.

For minors: Initials: _____: I hereby authorize and give consent to routine evaluation and treatment to my daughter/son, and/or transport to the nearest available hospital. I reserve, as guardian or legal representative to my daughter/son, and/or dependent, the right to refuse specific services at anytime.

I consent to the administration of medications and injection deemed necessary in the judgment of Payam Vahedifar, M.D.

I recognize that the practice of medicine is not an exact science and Dr. Vahediar does not guarantee the results of treatment.

_____ _____

Patient / Guardian Signature Date

Nuvo Spine & Sports Institute

INSTRUCTIONS TO COMPLETE THIS FORM:
- Completely **fill in the circle** next to the appropriate answer to each question.
- DO NOT WRITE in explanations or comments in circle areas.
- ONLY WRITE COMMENTS OR ADDITIONAL INFORMATION IN COMMENT SECTIONS.
- If you do not understand how to complete this form, please ask for assistance.

Referring Physician: _____ **Primary Care Physician:** _____

ORTHOPEDIC HISTORY - ADULT

PATIENT NAME: _____ TODAY'S DATE: _____

BIRTH DATE: _____ AGE: _____ SEX: O Male O Female O right-handed O left-handed

Why are you seeing the doctor today? *(ONLY select the most severe area you would like to address today)*

O R Shoulder	O R Hand	O R Clavicle	O R Knee	O R Foot	O Lower leg
O L Shoulder	O L Hand	O L Clavicle	O L Knee	O L Foot	O Thigh
O R Elbow	O R Wrist	O R Hip	O R Ankle	O Neck	
O L Elbow	O L Wrist	O L Hip	O L Ankle	O Mid Back	O Low Back

Is your complaint(s) related to an injury? O Yes O No If no, how long have you had your symptoms ?_____

If yes, when did your injury occur?: _____ How did your injury occur? _____

Location of Pain / Area / Contributing Factors:

Neck:	O down arm	O numbness	O bending backward	O bending forward
Shoulder:	O overhead activity	O reaching	O numbness in fingers	O tingling in fingers
Elbow:	O inside	O outside	O back	
Wrist:	O top	O palm	O thumb side	O little finger side
Hand:	O into fingers			
Back:	O down leg(s)	O buttocks	O tingling in toes	O numbness in toes
Hip:	O groin	O buttock	O low back	O thigh
	O side of hip	O numbness in toes	O tingling in toes	
Knee:	O catching	O locking	O instability	O kneeling
Foot:	O top	O bottom	O outside	O heel
Ankle:	O inside	O outside	O front	O back
Timing of Pain:	O w/ prolonged walking	O at rest	O at night	
Type of Pain:	O burning	O throbbing	O aching	O shooting
	O stabbing	O cramping	O sharp	O dull
Duration of Pain:	O occasional	O intermittent	O constant	

REVIEW OF SYSTEMS

Only mark the conditions you have been diagnosed with. **(If the answer is *NO* leave it blank)**

Constitutional							
Fevers, chills, sweats	O No	O Yes		Change in appetite	O No	O Yes	
Excessive fatigue	O No	O Yes		Unintended weight loss	O No	O Yes	
Musculoskeletal							
RSD	O No	O Yes		Metal implants	O No	O Yes	
Swelling in multiple joints	O No	O Yes		Fibromyalgia	O No	O Yes	
Eyes, Ears, Nose & Throat							
Recent vision changes	O No	O Yes		Hearing loss	O No	O Yes	
Respiratory							
Wheezing	O No	O Yes		Chronic cough	O No	O Yes	
Cardiovascular							
Shortness of breath	O No	O Yes		Pacemaker	O No	O Yes	
Chest pain or angina	O No	O Yes					
Gastrointestinal							
Colon cancer	O No	O Yes		Ulcers/ Reflux	O No	O Yes	
Skin							
Skin cancer or melanoma	O No	O Yes		Eczema or psoriasis	O No	O Yes	
Neurological							
Stroke	O No	O Yes		Seizures	O No	O Yes	
Genitourinary							
Bladder infections	O No	O Yes		Difficulty with urination	O No	O Yes	
Kidney stones	O No	O Yes		Prostate problems	O No	O Yes	
Endocrine							
Diabetes	O No	O Yes		Taking prednisone	O No	O Yes	
Thyroid problem	O No	O Yes					
Hematological/ Immunological							
Anemia	O No	O Yes		Easy bruising/ bleeding	O No	O Yes	
Blood transfusion	O No	O Yes					
Psychology							
Depression	O No	O Yes		Eating disorder	O No	O Yes	
Panic attack	O No	O Yes					

RATE YOUR PAIN

(fill in the circle that best describes your level of pain)

(no pain) Pain Scale (worst)

O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10

Are you taking any pain medications? O Yes O No Drug Name: _____

Does your medication for pain help? O Yes O No O Not Adequate

Non-operative Treatments:	O Physical Therapy		O Bracing	O Heat/Ice
	O Cortisone		O Viscosupplementation	O Epidurals
I am able to walk:	O only in my home		O less than 5 blocks	
	O more than 5 blocks		O more than 1 mile	
I use assistive devices:	O walker at home	O Crutches	O walker in the community	
	O cane at home	O Walker boot	O cane in the community	
	O wheelchair at home		O wheelchair in the community	

MEDICAL HISTORY

I have been diagnosed with the following conditions:

O Peripheral Vascular Disease	O Gout	O Lung Cancer	O Diabetes
O Coronary Artery Disease	O Rheumatoid Arthritis	O Breast Cancer	O Neuropathy
O High Blood Pressure	O Asthma/COPD	O Colon Cancer	O Stroke
O Reflux Disease (GERD)	O Prostate Cancer	O Thyroid Cancer	O Blood clot

Other: _____

SOCIAL HISTORY

O Single O Married O Divorced O Widowed O Domestic Partner

Do you live alone? O Yes O No Do you have stairs in your home? O Yes O No

What type of work do you do? _____

Smoke Cigarettes?	O Yes		O No	O have previously
Packs per day	O less than 1		O 1 – 2	O more than 2
How long have you smoked?	O less than 1 year		O more than 5 years	O more than 10 years
Drink Alcohol?	O Never	O Rarely	O Weekly	O Daily
Do you have a history of substance abuse?		O Yes	O No	
Do you have a history of exposure to hepatitis or AIDS?		O Yes	O No	

FAMILY HISTORY

Member	Alive	Deceased	Age	Health status or cause of death
Father	O	O		
Mother	O	O		
Siblings	O	O		
How many siblings do you have: O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8				

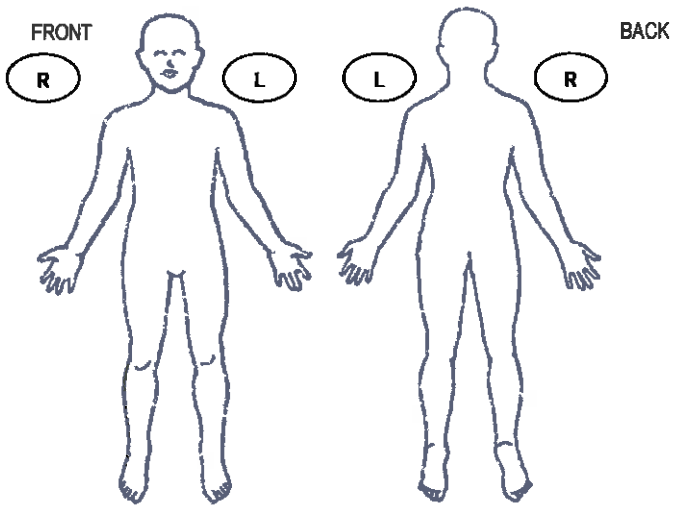
SURGICAL HISTORY

Please write in all surgical procedures you have had in the past including the date of surgery:

Surgical Procedure (s) Date

Have you ever had any problems with anesthesia?	O Yes	O No
List all medications and doses: (write in answer)	O Coumadin	O Plavix
Allergies (drug & food): (write in answer)		

Mark the areas where the sensations travel, if any. Please include ALL affected areas.



PATIENT SIGNATURE: _____ DATE: _____

PAYAM VAHEDIFAR, M.D.

Pain Management

818-986-0200

FINANCIAL POLICY

We welcome you to Dr. Vahedifar's office. The following are our financial policies regarding the services you receive from Payam Vahedifar, M.D. here at the clinic and procedure facilities.

1. All patients will provide accurate and complete personal and insurance information.
2. All applicable co-pays, co-insurance, deductibles and personal balances (current & prior) are due at the time of service.
3. Payment can be made by cash, and all major credit cards and debit cards. We do not place cards on file. **WE DO NOT ACCEPT CHECKS IN ANY FORM**

Insurance and Payments: Dr. Vahedifar is a participating provider for **United Healthcare PPO, Cigna PPO, Aetna PPO, Health Net PPO, Multiplan/PHCS/Beech Street PPO and Medicare**. Dr. Vahedifar participates in some plans administered by Blue Cross PPO, and Blue Shield PPO. **Dr. Vahedifar does not participate in any HMO plans and Covered California exchange plans also known as ObamaCare, Medi-Cal or other government based insurance companies.**

There are a large variety of plans introduced on an almost daily basis. Therefore, it is YOUR responsibility to contact your insurance company prior to treatment with Dr. Vahedifar to determine whether or not Dr. Vahedifar is a provider on your plan and verify any co-pays, co-insurance and deductibles under your policy.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures which they sometimes refer to as "reasonable and customary fees." Depending on your plan, your insurance may only pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance.

In order to control your cost of billings, we do request that we collect any unpaid deductibles, co-insurance and co-pays for office visits and any procedures done in the office at the conclusion of EACH VISIT.

Financial Difficulties: If you have any concerns regarding payment of your bill prior to seeing the doctor, we will make every effort to assist patients who bring this issue to our attention before services are provided.

Procedures: Prior to any procedure, an estimated cost analysis will be provided. It is your responsibility to pay the deductible and/or coinsurance at least seven (7) days prior to scheduled procedure date. There will be a cancellation fee for all non-medical cancellations. You will be consented separately for procedures.

Durable Medical Equipment Products: Most durable medical equipment is not covered by insurance. All supports and splints dispensed are non-refundable.

Form Fee's and Medical Records Copy Fee: There is a form fee for any forms that need to be completed by Payam Vahedifar, MD. The forms and fees are as follows: **State Disability Form:** $ 60.00, **EDD Form:** $60.00, **Jury Duty Form:** $ 30.00, **DMV Placard Form:** $ 20.00, **Dept. of Social Service Form:** $ 60.00, **Employer Forms:** $ 60.00, **Private Disability Insurance Form:** $ 60.00, **Patient Medical Records Copy**: $ 60.00, **X-Ray CD Copy:** $ 20.00

Assignment of Benefits: I hereby authorize my insurance benefits to be paid directly to Payam Vahedifar, M.D. I hereby instruct and direct my insurance company to pay by checks made payable to Payam Vahedifar, M.D. and mail to 16633 Ventura Blvd., Suite 802, Encino, CA. 91436. I understand that I am personally responsible for payments which my insurance company/managed care company will not cover if they say an office visit, procedure or pathology, etc…is not " medically necessary", "pre-existing", etc…or related to the deductibles or co-payments, or for any other reason they give for non-payment. I also understand that what my carrier considers "not medically necessary" may, on the contrary, be considered medically necessary by Payam Vahedifar, M.D.

I authorize Payam Vahedifar, M.D. to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. I have read, understand and agree to the above financial policy.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

_____ _____

Patient Signature Date

Pain Management Patient Agreement
Payam Vahedifar, M.D.

I, _____, agree that effective today_____ and going forward, that Payam Vahedifar, M.D. will be my pain management physician. Dr. Vahedifar will take care of all my pain management needs including filling out prescriptions, follow-up evaluations, and any narcotic or non narcotic medications associated with my pain management regimen. I also agree that the following will apply to this contract in order for me to obtain or continue to obtain ongoing care with/from Dr. Vahedifar.

1. All Medications for pain management will be prescribed by Dr. Vahedifar and only Dr. Vahedifar. I will not seek additional medication or augment my pain management regimen by any other physician.

2. Pain medications will not be refilled over the telephone – in order to receive a refill for pain management medication I am required to make an appointment for an office visit and physically be present during that appointment in order to obtain a refill, if the refill is deemed appropriate by Dr. Vahedifar.

3. Any medications that are lost, stolen or otherwise misplaced are my responsibility, the patient, not Dr. Vahedifar. I will protect my medication, and I will take responsibility for any stolen or lost medication. I understand that I will not receive refills for those lost/misplaced medications until the original quantity issued date has expired.

4. I will not take more than the prescribed amount of medication in any given 30 days of the prescription period.

5. If the medications are taken from other patients or given to other patients, this would be fraudulent and against the law, and will be reported by Dr. Vahedifar to the proper authorities.

6. I will obtain all my medication refills at:

_____ _____

Print Name of Pharmacy **Pharmacy Telephone Number**

7. I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from Dr. Payam Vahedifar care.

8. I understand that failure to comply with any of the above conditions or failure to make regular follow-up appointment with my primary care provider may result in termination of prescriptions for narcotic or any other pain management medication. ***Any deviation to the above may also result in being prevented from receiving any further care.***

I have read the above and understand my rights and responsibilities for pain management through Dr. Vahedifar and I will comply with all of the above guidelines. Again, if I fail to comply I understand that I may be dismissed as a patient of Dr. Vahedifar as well as Encino Spine.

Patient Signature: _____ **Date:** _____

NUVO®
SPINE AND SPORTS INSTITUTE
PAYAM VAHEDIFAR, M.D.

DISCLOSURE AND AUTHORIZATION FORM FOR PATIENT REFERRAL TO OTHER NON-PARTICIPATING PHYSICIAN(S) OR FACILITIES

Patient Name: _____ Attending Physician: **Dr. Vahedifar**

Provider/Entity: **90210 Surgery Medical Center/Precision Surgery Center/Radiance Surgery Center**

Dear Patient:

To serve you with the highest quality care and safety at the most affordable cost, sometimes it is necessary and important to have other providers or entities join our team to complete or continue your procedure(s) in order to assure your speedy recovery. We would like to keep you informed of your choice and our recommendation of these other providers or entities and obtain your informed authorization before making our referral and scheduling your next procedure(s).

Since no provider or entity could be participating in every managed care network, such as the one your health plan has contracted with, these other providers or entities may or may not be participating in your health plan's network. This Form is used to inform you of our verification that the above named providers or entities are non-participating providers or entities with your health plan.

As a courtesy to you, we have verified your insurance coverage for non-participating providers or entities and for recommended procedures, and we have obtained pre-certification, if applicable, for all services.

Please understand that your insurer or health plan may take the position that insurance verification is not a guarantee of insurance payment according to your health plan.

If you have any questions concerning your out-of-network benefits or financial obligations under your benefits plan when using an out-of-network provider, please call the member services number written on your Insurance Identification Card.

Acknowledgement Regarding Disclosure of Beneficial Interest
In connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation of provider/facility and patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, I acknowledge that my attending doctor(s) and/or clinic (facility) have disclosed to me at the time of initial contact and at the time of referral any significant beneficial interest they or their immediate family members might have in connection with the referral, including (A) his/her affiliation, if any, with the doctor or facility to whom I am being referred and (B) that he/she will receive, directly or indirectly, remuneration for the referral. I acknowledge that I may exercise my rights of freedom of choice for the providers and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, including without limitation Medicare, ERISA, PPACA and the California Business and Professions Code.

Doctor or Facility with significant beneficial interest: **Dr. Vahedifar**

I certify that I was informed of the effective alternative resources reasonably available at the time of my decision-making, and my option to use one of the alternative resources, and that I was assured by my attending physician that I will not be treated differently by the physician and his/her staff if I choose an alternative provider or entity.

I certify my decision to accept the referral made by my attending doctor(s) and/or clinic (facility) has been as the result of my informed choice for the quality and safety of the care that I will be expecting and receiving. My decision is informed by, among other factors, the provider's professional reputation for providing quality and affordable healthcare that I personally expect under my health plan for out-of-network coverage.

I have read and fully understand this Disclosure and Authorization Form. I hereby authorize this referral to non-participating and out-of-network provider(s) or entities as named above.

_____	**X** _____	_____
Patient Name (or Guardian)	Patient Signature (or Guardian)	Date

BEVERLY HILLS
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