

# 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: \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

### RESPONSIBILITY 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

# 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

# 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:  Male  Female  right-handed  left-handed

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

- |                                  |                               |                                  |                               |                                |                                 |
|----------------------------------|-------------------------------|----------------------------------|-------------------------------|--------------------------------|---------------------------------|
| <input type="radio"/> R Shoulder | <input type="radio"/> R Hand  | <input type="radio"/> R Clavicle | <input type="radio"/> R Knee  | <input type="radio"/> R Foot   | <input type="radio"/> Lower leg |
| <input type="radio"/> L Shoulder | <input type="radio"/> L Hand  | <input type="radio"/> L Clavicle | <input type="radio"/> L Knee  | <input type="radio"/> L Foot   | <input type="radio"/> Thigh     |
| <input type="radio"/> R Elbow    | <input type="radio"/> R Wrist | <input type="radio"/> R Hip      | <input type="radio"/> R Ankle | <input type="radio"/> Neck     |                                 |
| <input type="radio"/> L Elbow    | <input type="radio"/> L Wrist | <input type="radio"/> L Hip      | <input type="radio"/> L Ankle | <input type="radio"/> Mid Back | <input type="radio"/> Low Back  |

Is your complaint(s) related to an injury?  Yes  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:	<input type="radio"/> down arm	<input type="radio"/> numbness	<input type="radio"/> bending backward	<input type="radio"/> bending forward
Shoulder:	<input type="radio"/> overhead activity	<input type="radio"/> reaching	<input type="radio"/> numbness in fingers	<input type="radio"/> tingling in fingers
Elbow:	<input type="radio"/> inside	<input type="radio"/> outside	<input type="radio"/> back	
Wrist:	<input type="radio"/> top	<input type="radio"/> palm	<input type="radio"/> thumb side	<input type="radio"/> little finger side
Hand:	<input type="radio"/> into fingers			
Back:	<input type="radio"/> down leg(s)	<input type="radio"/> buttocks	<input type="radio"/> tingling in toes	<input type="radio"/> numbness in toes
Hip:	<input type="radio"/> groin	<input type="radio"/> buttock	<input type="radio"/> low back	<input type="radio"/> thigh
	<input type="radio"/> side of hip	<input type="radio"/> numbness in toes	<input type="radio"/> tingling in toes	
Knee:	<input type="radio"/> catching	<input type="radio"/> locking	<input type="radio"/> instability	<input type="radio"/> kneeling
Foot:	<input type="radio"/> top	<input type="radio"/> bottom	<input type="radio"/> outside	<input type="radio"/> heel
Ankle:	<input type="radio"/> inside	<input type="radio"/> outside	<input type="radio"/> front	<input type="radio"/> back
Timing of Pain:	<input type="radio"/> w/ prolonged walking	<input type="radio"/> at rest	<input type="radio"/> at night	
Type of Pain:	<input type="radio"/> burning	<input type="radio"/> throbbing	<input type="radio"/> aching	<input type="radio"/> shooting
	<input type="radio"/> stabbing	<input type="radio"/> cramping	<input type="radio"/> sharp	<input type="radio"/> dull
Duration of Pain:	<input type="radio"/> occasional	<input type="radio"/> intermittent	<input type="radio"/> 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	<input type="radio"/>	No	<input type="radio"/>	Yes	Change in appetite	<input type="radio"/>	No	<input type="radio"/>	Yes
Excessive fatigue	<input type="radio"/>	No	<input type="radio"/>	Yes	Unintended weight loss	<input type="radio"/>	No	<input type="radio"/>	Yes

### **Musculoskeletal**

RSD	<input type="radio"/>	No	<input type="radio"/>	Yes	Metal implants	<input type="radio"/>	No	<input type="radio"/>	Yes
Swelling in multiple joints	<input type="radio"/>	No	<input type="radio"/>	Yes	Fibromyalgia	<input type="radio"/>	No	<input type="radio"/>	Yes

### **Eyes, Ears, Nose & Throat**

Recent vision changes	<input type="radio"/>	No	<input type="radio"/>	Yes	Hearing loss	<input type="radio"/>	No	<input type="radio"/>	Yes
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### **Respiratory**

Wheezing	<input type="radio"/>	No	<input type="radio"/>	Yes	Chronic cough	<input type="radio"/>	No	<input type="radio"/>	Yes
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### **Cardiovascular**

Shortness of breath	<input type="radio"/>	No	<input type="radio"/>	Yes	Pacemaker	<input type="radio"/>	No	<input type="radio"/>	Yes
Chest pain or angina	<input type="radio"/>	No	<input type="radio"/>	Yes					

### **Gastrointestinal**

Colon cancer	<input type="radio"/>	No	<input type="radio"/>	Yes	Ulcers/ Reflux	<input type="radio"/>	No	<input type="radio"/>	Yes
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### **Skin**

Skin cancer or melanoma	<input type="radio"/>	No	<input type="radio"/>	Yes	Eczema or psoriasis	<input type="radio"/>	No	<input type="radio"/>	Yes
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### **Neurological**

Stroke	<input type="radio"/>	No	<input type="radio"/>	Yes	Seizures	<input type="radio"/>	No	<input type="radio"/>	Yes
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### **Genitourinary**

Bladder infections	<input type="radio"/>	No	<input type="radio"/>	Yes	Difficulty with urination	<input type="radio"/>	No	<input type="radio"/>	Yes
Kidney stones	<input type="radio"/>	No	<input type="radio"/>	Yes	Prostate problems	<input type="radio"/>	No	<input type="radio"/>	Yes

### **Endocrine**

Diabetes	<input type="radio"/>	No	<input type="radio"/>	Yes	Taking prednisone	<input type="radio"/>	No	<input type="radio"/>	Yes
Thyroid problem	<input type="radio"/>	No	<input type="radio"/>	Yes					

### **Hematological/ Immunological**

Anemia	<input type="radio"/>	No	<input type="radio"/>	Yes	Easy bruising/ bleeding	<input type="radio"/>	No	<input type="radio"/>	Yes
Blood transfusion	<input type="radio"/>	No	<input type="radio"/>	Yes					

### **Psychology**

Depression	<input type="radio"/>	No	<input type="radio"/>	Yes	Eating disorder	<input type="radio"/>	No	<input type="radio"/>	Yes
Panic attack	<input type="radio"/>	No	<input type="radio"/>	Yes					

## FAMILY HISTORY

Member	Alive	Deceased	Age	Health status or cause of death
Father	<input type="radio"/>	<input type="radio"/>		
Mother	<input type="radio"/>	<input type="radio"/>		
Siblings	<input type="radio"/>	<input type="radio"/>		

How many siblings do you have:     0    1    2    3    4    5    6    7    8

## SURGICAL HISTORY

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

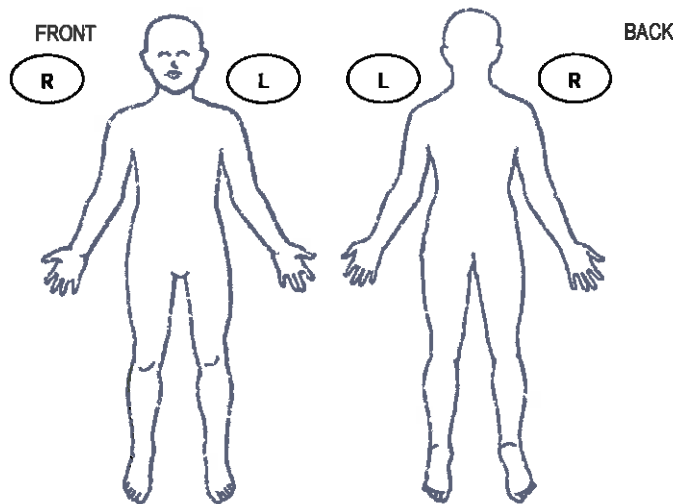
Surgical Procedure (s)	Date

Have you ever had any problems with anesthesia?	<input type="radio"/> Yes	<input type="radio"/> No
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List all medications and doses: (write in answer)	<input type="radio"/> Coumadin	<input type="radio"/> Plavix

Allergies (drug & food): (write in answer)	

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



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:** \_\_\_\_\_