SOHAIL SHAYFER, MD, INC.

Orthopaedic Surgery, Hand Surgery, & Sports Medicine

GENERAL PATIENT INFORMATION FORM

Patient Name: _____ Sex: _____ Birth Date: _____ Age: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ E-mail address: _____

In Case of Emergency Name: _____ Phone #: _____

Address: _____ Relationship: _____

How did you find us / referred to us? ☐ Doctor ☐ Friend/Family ☐ Attorney ☐ Self ☐ Internet ☐ Insurance

If injured, was the injury related to work? ☐ Yes ☐ No Employer: _____

If Auto Accident, auto policy name and number: _____

Is there an attorney involved? ☐ Yes ☐ No Attorney's name: _____

Address: _____ Phone #: _____

* * * * * * * * * * * * * * *

I CERTIFY THAT THE ABOVE IS CORRECT. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM. I ALSO REQUEST PAYMENT OF BENEFITS PAYABLE TO THE PARTY WHO ACCEPTS ASSIGNMENT. I AUTHORIZE DR. SOHAIL SHAYFER TO EXAMINE ME. I UNDERSTAND THAT IF SURGERY IS INDICATED, PAYMENT ARRANGEMENTS WILL BE MADE AND I AM RESPONSIBLE FOR MY BILL REGARDLESS OF INSURANCE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. I UNDERSTAND THAT PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED.

SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT OR GUARDIAN: _____ RELATIONSHIP: _____

Preferred Pharmacy: _____ City: _____ Phone: _____

Medical History Form

A complete history is invaluable in evaluation and management of most medical conditions. Seemingly unrelated conditions can be the key to discovering the correct diagnosis. Accordingly, we appreciate if you fill out the following form as thoroughly as possible.

Name of Private Medical Doctor: _____ Date: _____

Patient's name: _____

☐ Right handed ☐ Left handed Current Occupation: _____ Height: _____ Weight: _____

HISTORY OF PRESENT ILLNESS

Why are you seeing the doctor today?

Injury: ☐ Car ☐ Work ☐ Home ☐ Gym ☐ Other: _____ Date of injury/accident: _____

If there was no injury, when did the symptoms first start?

Is there a history of this or similar condition in the past? _____

Please tell us if you have seen another doctor regarding this condition: _____

Imaging (check all that apply):

☐ MRI Facility: _____ Date: _____ ☐ X-rays Facility: _____ Date: _____

☐ CT Facility: _____ Date: _____ ☐ EMG/NCS Doctor: _____ Date: _____

Treatments tried: ☐ Medication ☐ Bracing ☐ Cortisone injection ☐ PRP ☐ Physical therapy ☐ Chiropractic ☐ Surgery

Expand: _____

PAST MEDICAL HISTORY (check all that apply)

☐ Diabetes I	☐ Diabetes II	☐ Stomach Ulcers	☐ Migraine	☐ Depression	☐ Liver Disease/Hepatitis
☐ Arthritis	☐ Epilepsy	☐ Heart Disease	☐ Asthma	☐ Pneumonia	☐ High Blood Pressure
☐ Anxiety	☐ Obesity	☐ HIV	☐ GERD	☐ Psoriasis	☐ High Cholesterol
☐ Stroke	☐ Anemia	☐ Sleep Apnea	☐ Tuberculosis	☐ Osteoporosis	☐ Gallbladder Disease
☐ Alcoholism	☐ Drug Abuse	☐ Hypothyroidism	☐ Blood Clots	☐ Emphysema	☐ Kidney Disease

☐ Cancer - Type: _____ Other: _____

Past Surgeries / Hospitalizations	Year	Complications

List All Medications	Dose	Frequency

Hormone replacement - Men: ☐ Testosterone

Women: Estrogen (☐ pill ☐ patch ☐ vaginal ☐ other) ☐ Progesterone ☐ Testosterone

Are you currently taking anticoagulants? ☐ No ☐ Yes Describe: _____

Do you have any allergies to medications? ☐ No ☐ Yes Describe: _____

Most current vaccines (check and enter date):

☐ Covid Date: _____ ☐ Flu Date: _____ ☐ Pneumococcal Date: _____ ☐ Shingles Date: _____

SOCIAL HISTORY

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Student

Smoking Status:

☐ Never

☐ Currently every day - packs/day: _____

☐ Currently some days - packs/day: _____

☐ Former smoker - year you quit: _____

Alcohol Status:

☐ Never

☐ Currently every day - drinks/day: _____

☐ Currently some days - drinks/week: _____

☐ Former drinker - year you quit: _____

Do you have a history of substance abuse? ☐ No ☐ Yes Describe: _____

FAMILY HISTORY

Member	Alive	Deceased	Age	Health Status or Cause of Death
Maternal Grandparents	☐	☐		
Paternal Grandparents	☐	☐		
Mother	☐	☐		
Father	☐	☐		
Siblings	☐	☐		

SOHAIL SHAYFER, MD, INC.

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT AND PATIENT COMMUNICATION PREFERENCES

Patient name: _____ Date of birth: _____

Preferred name: _____ Today's date: _____

1. ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I received or was offered a copy of this practice's Notice of Privacy Practices. The Notice explains how my protected health information may be used or disclosed for treatment, payment, health care operations, and other purposes permitted or required by law, and describes my privacy rights.

My signature confirms receipt or offer of the Notice only. It is not a general authorization to release my medical records, and the practice may revise its Notice as permitted by law.

2. COMMUNICATION PREFERENCES

The practice may contact me about appointments, treatment, care coordination, billing, and other health care matters. Please use reasonable safeguards and follow these preferences when reasonably practicable:

Phone calls / voicemail Preferred number: _____

☐ Detailed message permitted ☐ Callback information only ☐ Do not leave voicemail

Text messages Mobile: _____

☐ Appointments / scheduling ☐ Billing / administrative ☐ Clinical information ☐ No text messages

Email Email: _____

☐ Appointments / administrative ☐ Clinical information / records ☐ No email

Email and ordinary text messaging may carry privacy risks. By selecting those methods, I request communication through the contact information I provided. I may change these preferences in writing.

3. PEOPLE THE PRACTICE MAY SPEAK WITH

I permit the practice to discuss information relevant to my care or payment with the person(s) below. This preference does not authorize release of an entire medical record and may be changed or revoked by me in writing.

1. Name: _____ Relationship: _____ Phone: _____

☐ Scheduling ☐ Billing ☐ Medical information ☐ All of these

2. Name: _____ Relationship: _____ Phone: _____

☐ Scheduling ☐ Billing ☐ Medical information ☐ All of these

☐ I do not authorize the practice to discuss my information with anyone other than me, except as permitted or required by law.

4. SIGNATURE

I have had an opportunity to ask questions. I understand that refusing to sign the acknowledgment does not prevent treatment, although the practice will document its good-faith effort to provide the Notice.

Patient / personal representative signature: _____ Date: _____

If signed by representative, print name: _____ Authority / relationship: _____

OFFICE USE ONLY - If acknowledgment was not obtained: ☐ Patient declined to sign ☐ Unable to obtain

Staff member: _____ Date: _____ Reason / efforts: _____

Patient Statement of Financial Responsibility and Other Information

Thank you for choosing Sohail Shayfer, MD for your healthcare needs. Our staff is committed to enhancing the quality of your care and overall health. This policy statement and release has been designed to inform you of our policies and answer your questions regarding payment of services.

Please be sure that you have read and understand all the information provided in this statement before signing the release. As our patient your signature is both binding and acknowledges your understanding and compliance with our policies.

Payment for Office Visits

For the convenience of our patients we accept cash, Visa, Master Card, traveler's checks and personal checks. Co-payments and deductibles required by individual insurance plans are due at the time the services are rendered. **Returned checks are subject to a $25 return fee.**

Payment for Surgery

Co-payments or deductibles toward surgery are the patient's responsibility and must be paid prior to the date of surgery. If payment is not received prior to surgery it will be postponed. Personal checks will **not** be accepted within two weeks of the surgery date.

Self-Pay Patients

We welcome self-paying patients when insurance coverage is not available for our services. Patients without insurance are asked to assume full financial responsibility for the office visit and medical services rendered during the time of service. *If for some reason full payment cannot be made at the time of service please speak with an administrator prior to your office visit to determine if reasonable payment arrangements can be established.*

Delinquent Accounts

Your account will be considered delinquent after 30 days and fee of 2% per month will apply beginning at the first of each month until the account is paid in full. If your account is turned over to a collections agency you will be responsible for the collections fee as well as the account balance. No further services will be rendered until the account is paid and in good standing.

Cancellations and Missed Appointments

In order to be respectful of the medical needs of others please be courteous and call our office at least 24-hours in advance if you are unable to attend or must reschedule an appointment. A fee of $50.00 will be billed to your account if your appointment is missed or if you do not cancel within the appointed time. For your convenience our phone line, (818) 981-3688, is covered 24-hours a day.

Medical Supplies and X-Rays

Your insurance plan may cover medical supplies and x-rays partially or not at all. We will do our best to abide by your insurance policy and bill them appropriately. However, you will be billed directly if your insurance company denies charges for medical supplies and/or x-rays. Upon request, we will provide you with a cost estimate of all services and supplies.

Medicare Patients

We accept Medicare assignment of covered Medicare charges. Patients will be billed for the $100.00 annual deductible or any uncovered charges unless the patient has a supplemental insurance. The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

Worker's Compensation Patients

We must have prior authorization to treat from either the employer or the insurance carrier agent. Should the employer or carrier subsequently deny a validated worker's compensation service, such charges will be the financial responsibility of the patient.

Personal Injury Patients

Patients with representation must have a signed lien agreement and authorization prior to being seen. It is the patient's responsibility to communicate a change in status to our office if services had previously been billed to a private insurance carrier.

RELEASE

I hereby acknowledge that I have read, understand and agree to comply with all policies outlined herein. I also acknowledge should my account go to collections, I will be charged the collections service fee in addition to all outstanding balances.

Signature of Patient/Guarantor: _____ Date: _____

Print name: _____