LA Vascular & Endovascular Surgery

Sasan Najibi, M.D., F.A,C.S. **John Conrad, M.D., F.A.C.S.**

Patient Demographic Sheet

Name: _____ _____ Date: _____
Last First

Date of Birth: _____ Sex: _____ Age: _____

Address: _____ _____ _____
Street City/State Zip Code

Cell #: _____ Home #: _____

Email: _____

Social Security No.: _____

Next of Kin/Emergency Contact: _____

Relationship to Patient: _____ Telephone #: _____

Referring Provider Name: _____

Referring Provider Address: _____

Referring Provider Telephone #: _____

Primary Care Physician Name: _____

Primary Care Physician Address: _____

Primary Care Physician Telephone #: _____

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Please Note: You are responsible for all co-payments and deductibles. Please be prepared to pay your co-payments at the time of your visit.

I hereby authorize payment directly to L.A. Vascular and Endovascular Surgery for the surgical and/or medical benefits, if any, otherwise payable to me or professional services rendered to me. I understand that it is the patient/guarantor responsibility to know if L.A. Vascular and Endovascular Surgery is 'in' or 'out' of network for my insurance. If my insurance provider is out of network and I choose to be treated by L.A. Vascular and Endovascular Surgery, I may be responsible for higher out-of-pocket charges. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me. I further agree in the event of non-payment, to bear the cost of reasonable legal fees should this be required.

_____ _____

Date (mm/dd/yyyy) Signature of patient

I hereby authorize L.A. Vascular and Endovascular Surgery to disclose when treated by the above mentioned insurance carriers or its representatives, transmissions of portions of patient's medical records to physician's data corporation for electronic storage and retrieval. Any and all information with respect to any illness (es) or injury (ies). Medical history of treatment and copies of all medical records. A photostatic copy of this authorization shall be considered effective and valid as the original.

_____ _____

Date (mm/dd/yyyy) Signature of patient

SASAN NAJIBI, M.D., F.A.C.S.
JOHN CONRAD, M.D., F.A.C.S
L.A. VASCULAR & ENDOVASCULAR SURGERY
2950 W. Burbank Blvd., Burbank, CA 91505
Phone: (818) 558.7700 Fax: (818)558.7779

Acknowledgement of Receipt of Privacy Notice

Our practice has the right to modify the privacy practices outlined in this notice.

I have been presented with a copy of Notice of Privacy Policies for the medical practice of L.A. Vascular and Endovascular Surgery (Sasan Najibi, M.D.), detailing how my information may be used and disclosed as permitted under federal and state law.

Name of Patient (Please Print)	Signature of Patient	Date

Signature of Patient Representative (if patient is a minor or an adult unable to sign form)	Relationship of Representative to Patient	Date

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Authorization to Release Information

To: _____

_____

_____

This will authorize you to prepare medical reports and/or permit the bearer to review, inspect, copy, and/or photocopy; any or all of the following in your possession or control:

- Radiographic & Imaging films and reports
- Medical reports, records, charts, and notes.

Photostatic copies of this authorization will be considered as valid as the original signature.

Date	Patient or Representative's Signature

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members/Patient Representative

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request protected health information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members or patient representative you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize **LA Vascular and Endovascular Surgery** to release my records and any information requested to the following individuals.

1. _____ Relation to Patient:_____
2. _____ Relation to Patient:_____
3. _____ Relation to Patient:_____
4. _____ Relation to Patient:_____

Authorization Regarding Messages
(please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments

____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

____ I authorize you to leave a message with anyone who answers the phone

____ Messages may only be left with _____

_____ _____
Patient Name (PLEASE PRINT) Date

_____ Patient Signature

Patient Acknowledgement of Ultrasound Cancellation Policy

Dear Patient,

LA Vascular and Endovascular Surgery has introduced an Ultrasound Cancellation Policy. A cancellation made with less than a 24 hour notice significantly limits our ability to make the appointment available for another patient in need.

To remain consistent with our patient care, we have introduced the following policy:

1. Please provide our office a 24-hour notice in the event that you need to reschedule your appointment. This will allow us the opportunity to provide care to another patient. A message can always be left with the answering service to avoid a cancellation fee being charged.
2. A "No-Show", "No-Call" or missed appointment, without proper 24-hour notification, may be assessed a $100 fee.
3. This fee is not billable to your insurance and will be billed to you.
4. If you are 15 or more minutes late for your appointment, the appointment may be cancelled and rescheduled.
5. As a courtesy, we make reminder calls, for appointments, two days in advance. Please note, if a reminder call or message is not received, the cancellation policy remains in effect.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify. A copy of this policy will be provided to you. Please sign and date below your acknowledgement.

I have read and understand the Appointment Cancellation Policy and I acknowledge its terms. I also understand and agree that such terms may be amended from time-to-time by our office.

_____	_____	_____
Printed Name of Patient	Signature of Patient	Date

TO OUR PATIENTS:

Beginning January 1, 2022, all prescriptions issued by a licensed prescriber will need to be done electronically pursuant to Assembly Bill (AB) 2789.

Please provide us with your preferred pharmacy information:

First & Last name:	Date of Birth:
Pharmacy Name:	
Address:	
Phone #:	Fax #:
Additional info:	

Medication List

Prescription Name	Dosage