Limb Lengthening Institute of Los Angeles
Dr. Shahab Mahboubian D.O.
Dr. Alireza Khosroabadi DPM
622 W Duarte Rd # 303 Arcadia CA 91007
Tel:310-985-6900
Fax:626-447-3704

PATIENT INFORMATION

Last Name: _____ First Name:_____ Middle Initial:_____

Street Address:_____ Home Phone:_____

City:_____ Work Phone:_____

State:_____ Zip:_____ Mobile Phone:_____

Date of Birth:_____ Age:_____ SSN#:_____ Occupation:_____

Email:_____ (**very important**)

Employer:_____ Emp. Phone:_____ Ext_____

Emergency Contact:_____ Emergency Phone:_____

REFERRED BY: _____ **Your Primary MD Name:** _____

MEDICAL HISTORY

What is the Condition that brought you in today?

……...……

……

Do you have pain? ☐Yes ☐ No

If yes, answer these questions

Pain Type

☐Sharp ☐Dull
☐Throbbing ☐ Burning

Location:…….

Duration:…….

Condition:

Worse Better No change

Prior Treatment: ☐Y ☐ N

Do you have :

Diabetes	☐Y	☐N
Hypertension	☐Y	☐N
Kidney Disease	☐Y	☐N
Heart Disease	☐Y	☐N
Arthritis	☐Y	☐N
Stroke	☐Y	☐N
Fever	☐Y	☐N
AIDS	☐Y	☐N

Other:……..

Prior surgery:……...

Do you Smoke? ☐Y ☐ N
How long? …….

Use Alcohol? ☐Y ☐ N
How much? ……

Family Medical History:

Diabetes Mellitus	☐Y	☐N
Hypertension	☐Y	☐N
Kidney Disease	☐Y	☐N
Cancer	☐Y	☐N

Allergies:----------
Medications:

_____

_____

HIPPA CONSENT FORM
PLEASE REVIEW THIS SUMMARY CAREFULLY

1. OUR LEGAL DUTY:
We are required by law to protect the Privacy of your health information, to provide a notice concerning Privacy practices, to follow the Privacy practices that we describe in our Notice of Privacy, and seek your acknowledgement of receipt of this notice. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you and how you can get access to this information. Our Notice contains a patient's Rights section describing your rights under the law. You have the right to review and request a copy of our notice of Privacy practices before signing this consent. The terms of our notice may change. If we change our Notice, you may obtain a revised copy by contacting our Office.

2. HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION:
By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment, and health care operations. For example, your health information may be shared with other providers to whom you are referred. You have the right to revoke this consent by requesting that in writing. However, such revocation shall not affect any disclosure we have already made in reliance upon your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

3. Your Rights:
You have the right to look at or get a copy of your health information, and if you request a copy, we may charge you a fee. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or request that we correct the information or add any missing information.

4. Privacy complaints:
If you are concerned that we have violated your Privacy rights, out Privacy policies, or if you disagree with the decision we have made about access to your health information, you may contact our Privacy Officer listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

The Patient Understands that:

1. Protected health information may be disclosed or used for treatment , payment, or health care operations.
2. Our practice has a Notice of Privacy Practices and that you the patient, have the opportunity to review this notice.
3. The practice reserves the right to change this Notice of Privacy Practices.
4. The patient has the right to restrict the uses of their information but the Practice does not have to agree to these restrictions
5. The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
6. The Practice may condition receipt of treatment upon the execution of this consent.
7. If you have any questions or complaints, please contact our Privacy Office

Privacy for Limb lengthening instate of Los Angeles

INSURANCE INFORMATION

Name of Insurance co: _____ ID#/Group# : _____

Name of Insured:_____ ID# / Group # : _____

Other Insurance: _____ Copay: _____

DOB: _____ SSN# _____

Relationship to patients: _____

ASSIGNMENT & RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with above insurance company(s) and assign directly to **Dr. Alireza Khosroabady** or **Dr. Shahab Mahboubian** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charge whether or not paid by insurance. I herby authorize the doctor to release all information necessary to secure the payment of benefits.
I authorize the use of this signature on all insurance submissions. I also certify that I have read and understand the **HIPPA PATIENT CONSENT FORM**.
I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be necessary in my diagnosis and/ or treatment.

Patient's Signature: _____ Date: _____

I _____ , authorize Limb Lengthening Institute of Los Angeles to charge my credit card
(NAME) (COMPANY)

For Consultation Fee.

AMOUNT $__600.00_____USD.
CREDIT CARD TYPE VISA MC AMEX DISC

CREDIT CARD # _____ CARD CV2 # _____

EXPIRATION DATE _____

BILLING ADDRESS _____ _____ BILLING ZIP CODE _____

NAME ON CARD _____
(As it appears on card)

****NOTE: Consultations for the Height Lengthening procedure will be performed in our North Hollywood office with Dr. Mahboubian.**

A **$100.00** fee will be charged for no shows .
If you cannot make it to your appointment, you are required to give us 48hr notice; otherwise you will be subject to $100.00 fee.

_____ _____
SIGNATURE DATE

Please either Fax or email the complete form to:

Fax : 626-447-3704
Email : info@lllila.com