NOTICE AND ACKNOWLEDGMENT OF RECEIPT AND UNDERSTANDING

NOTICE TO PATIENTS

Medical doctors are licensed and regulated by the Medical Board of California.

To check up on a license or to file a complaint go to

www.mbc.ca.gov,

email: licensecheck@mbc.ca.gov,

or call (800) 633-2322.

____
Date

____
Patient's Name (Type or Print)

____
Patient's Signature

____
Date

____
Patient Representative's Name and Relationship (Type or Print)

____
Patient's Representative's Signature

Original to be maintained in patient's medical records.

or any personal representatives may have against the clinic or Dr. Nik's Foot & Ankle Center or his staff with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services received from P. Benjamin Nikravesh, D.P.M . This liability waiver and release extends to the clinic together with the physician(s), physician assistants and employees.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that P. Benjamin Nikravesh, D.P.M and all the staff at Dr. Nik's Foot & Ankle Center are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this visit/elective treatment/procedure. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective visit/treatment/procedure, and I give my express permission for P. Benjamin Nikravesh, D.P.M and all the staff at Dr. Nik's Foot & Ankle Center to proceed with the same.

I understand that possible exposure to COVID-19 before/during/after visit my treatment/procedure may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short- term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective visit/treatment/procedure, I may need additional care that may require me to go to an emergency room or a hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the visit/treatment/procedure itself.

________________________ ______________________________

Name (print) Signature Date

I have been offered a copy of this consent form (patient's initials) ___

INFORMED CONSENT FOR COVID-19 RISK

I attest that:

*** I AM NOT EXPERIENCING ANY SYMPTOM OF ILLNESS SUCH AS COUGH, SHORTNESS OF BREATH OR DIFFICULTY BREATHING, FEVER, CHILLS, REPEATED SHAKING WITH CHILLS, MUSCLE PAIN, HEADACHE, SORE THROAT, OR NEW LOSS OF TASTE OR SMELL.**

*** I HAVE NOT TRAVELED INTERNATIONALLY WITHIN THE LAST 14 DAYS.**

*** I HAVE NOT TRAVELED TO A HIGHLY IMPACTED AREA WITHIN THE UNITED STATES OF AMERICA IN THE LAST 14 DAYS.**

*** I DO NOT BELIEVE I HAVE BEEN EXPOSED TO SOMEONE WITH A SUSPECTED AND/OR CONFIRMED CASE OF THE CORONAVIRUS/COVID-19.**

*** I HAVE NOT BEEN DIAGNOSED WITH CORONAVIRUS/COVID-19 AND NOT YET CLEARED AS NON CONTAGIOUS BY STATE OR LOCAL PUBLIC HEALTH AUTHORITIES.**

*** I AM FOLLOWING ALL CDC RECOMMENDED GUIDELINES AS MUCH AS POSSIBLE AND LIMITING MY EXPOSURE TO THE CORONAVIRUS/COVID-19.**

I acknowledge the contagious nature of the Coronavirus/COVID-19 and that the CDC and many other public health authorities still recommend practicing social distancing.

I further acknowledge that P. Benjamin Nikravesh, D.P.M has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19.

I further acknowledge that P. Benjamin Nikravesh, D.P.M can not guarantee that I will not become infected with the Coronavirus/Covid-19. I understand that the risk of becoming exposed to and/or infected by the Coronavirus/COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, clinic staff, and other patients and their families.

I voluntarily seek services provided by P. Benjamin Nikravesh, D.P.M and acknowledge that I am increasing my risk to exposure to the Coronavirus/COVID-19. I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment.

I hereby release and agree to hold P. Benjamin Nikravesh, D.P.M harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of the clinic or doctor, or that may otherwise arise in any way in connection with any services received from P. Benjamin Nikravesh, D.P.M . I understand that this release discharges P. Benjamin Nikravesh, D.P.M from any liability or claim that I, my heirs,

Communication by Email & Text Message

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Dr. P Benjamin Nikravesh and/or Dr. Nik's Foot & Ankle Center and its agents there is a reasonable chance that a third party may be able to intercept those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS/ SOCIAL MEDIA

I consent to allow Dr. P Benjamin Nikravesh, D.P.M. and/or Dr. Nik's Foot & Ankle Center and its agents to use unsecured email and mobile phone text to transit to me the following protected health information:

- Appointment Reminders
- Health Related Information
- Marketing offers

I consent to allow Dr. P Benjamin Nikravesh, D.P.M. and/or Dr. Nik's Foot & Ankle Center to use photographs or videos of me/ my child, on their social media tools which includes the follwoing: Instagram & Facebook page. I understand that these images and/or videos will not be used for any other commercial purposes.

I have been informed of the risk, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that message & data rates may apply. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Patient Signature ______________________ Date __________

6404 Wilshire Blvd • Suite 600 • Los Angeles, CA 90048
323-782-8586 • fax 323-782-8528

P B NIKRAVESH DPM APC

Receipt of notice of Privacy Practices
Written Acknowledgment Form

I, ____, have received a copy of the Notice of Privacy Practices From PB NIKRAVESH DPM APC, 6404 WILSHIRE BLVD #600 , LA CA 90048.

______________ ______________________________

Date Signature of Patient

Name____ Date______________________

SOCIAL HISTORY

Do you smoke? ☐ No ☐ Yes Number of packs per day _______ Number of years smoking ________
Do you drink? ☐ No ☐ Yes Drinks per day ______ Per week _____ Number of years drinking _____

Activity level ☐ sedentary light walking ☐ moderate light running/walking ☐ very active athlete

REVIEW OF SYSTEMS Please check all that apply

LUNG/RESPIRATORY ☐ None
☐ wheezing ☐ coughing up blood ☐ difficulty breathing ☐ frequent coughing ☐ shortness of breath
☐ painful breathing ☐ bronchitis☐ pneumonia

CARDIOVASCULAR ☐ None
☐ rapid/skipped beats ☐ high/low blood pressure ☐ fainting ☐ chest pains ☐ swollen ankles

GASTROINTESTINAL/DIGESTION ☐ None
☐loose bowels ☐constipation ☐ bloating ☐gas ☐ abdominal pain ☐ Denies nausea ☐ blood in stools
☐frequent belching☐ hemorrhoids ☐heart burn ☐vomiting

URINARY ☐ None
☐frequent urination ☐pain on urination☐ brown/black ☐bloody urine ☐ bladder infections
☐ unable to hold urine or a constant urge to urinate

MUSCULOSKELETAL ☐ None
☐muscle spasms or cramps ☐weakness in arms/legs ☐ numbness ☐ joint stiffness

SKIN ☐ None
☐ hair loss ☐rashes☐hives ☐dryness ☐itching ☐bruise easily ☐ growth or ulcerations

NEUROLOGICAL/ HEAD ☐ None
☐ headaches/migraines ☐ ringing in ears ☐ contact lenses ☐ wears glasses ☐ glaucoma
☐ blurry vision☐ seeing halos or lights☐ night blindness ☐ dizziness +head injury +eye pain ☐ cataracts

Sinus/Ear/Nose/Throat ☐ None
☐ frequent colds ☐ sore throats ☐ sore or bleeding gums ☐ impaired hearing ☐ nosebleeds ☐ hoarse voice
☐ sinus problems ☐ earaches ☐ sores on lips or tongue ☐ difficulty swallowing ☐ stuffiness

Endocrine ☐ None
☐ cold hands and feet ☐ gain weight easily ☐ heat or cold intolerance ☐ excessive thirst ☐ excessive
☐ hot flashes ☐ chronic fatigue ☐ have lost a lot of weight recently

I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance.

Signature: ______________________________ Date: ____________________________

MEDICAL HISTORY

TO AVOID ANY DELAY PLEASE FILL OUT **ALL** INFORMATION ☺

Name______________________________________ Date______________________

Height_______ Weight_________ Age_____ Sex_____ Shoe size________

PRIMARY CARE PHYSICIAN

Name ____ Date of last exam ______________

Address____________________________________ Telephone ___________________________

PAST INJURIES/SURGERIES please include APPROXIMATE DATE, PHYSICIAN/ HOSPITAL (sport & others i.e.; sprains, fractures, MVA etc.) (**THIS INFORMATION IS COMPLETELY CONFIDENTIAL!!**)

☐ None

____

____

____

Please list all **Medications** you are currently taking ☐ None

____

____

FOR **WOMEN** ONLY Are you pregnant?____________ If so, how many months?____________

ALLERGIES Please check all that apply ☐ None

☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Tape ☐ Sulfa ☐ Keflex ☐ Food(shellfish)
☐ Local anesthetics (xylocaine/marcaine/novacaine) ☐ Betadine/iodine ☐ Ibuprofen (Advil/Motrin)
☐ other/explain________________________

PAST MEDICAL HISTORY If you have or had any of these problems please check all that apply. ☐ None

☐ heart disease ☐ rheumatoid arthritis ☐ osteoarthritis ☐ bleeding disorder ☐ stroke
☐ heart attack(MI) ☐ neurological disorder ☐ seizure disorders ☐ hypertension(high blood pressure)
☐ diabetes (insulin/pill/diet) ☐ fainting ☐ anemia ☐ kidney diseases ☐ hepatitis ☐ HIV
☐ ulcers/stomach ☐ circulatory disorders ☐ high cholesterol ☐ other/explain ____________________

FAMILY HISTORY (blood relative) Please check all that apply. ☐ None
☐ Diabetes ☐ bleeding disorders ☐ genetic abnormalities ☐ neurological disorders ☐ other______
☐Mother ☐Father ☐Brother☐ Sister is Deceased Cause of death______________________________
☐Mother ☐Father ☐Brother☐ Sister is Deceased Cause of death______________________________

PATIENT REGISTRATION

TODAYS DATE__________________ HOME PHONE_______________________

NAME____ DATE OF BIRTH_____________________

ADDRESS____

CITY_______________________ STATE_______ ZIP CODE____________________

WORK PHONE__________________________ CELLULAR/PGR_________________________

Email Address:____

SOCIAL SECURITY NUMBER_________________**DRIVERS LICENSE NUMBER** ________________

EMPLOYED BY_____________________________OCCUPATION____________________________

EMERGENCY CONTACT
INFORMATION____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE?_____________________________

ADDRESS______________________________________PHONE NUMBER_____________________

AUTHORIZATIONS

I hereby consent to and authorize the administration of all emergency, diagnostic and therapeutic treatment for me and/or my minor child that may be necessary in the judgment of Dr Nikravesh. I hereby authorize Dr. Nikravesh and any laboratories used by Dr. Nikravesh for me, to furnish information (irregardless of sensitivity) to insurance carriers and I authorize and instruct these same insurance carriers to make payments directly to Dr. Nikravesh and laboratory for the medical expenses benefits. A Copy of this assignment and authorization shall be considered as effective and valid as the original. This lien is irrevocable.

I also understand that I am financially responsible to Dr. Nikravesh and laboratory for charges not covered and/or paid by my insurance carrier. If I do not pay said fees I will be responsible for all fees related to its collection. I understand **any balance over 30 days will be subject to a 10% APR interest. All charges related to its collection i.e. attorney fees, court costs, collection fees**. will be your responsibility (parent(s) if minor)

H.M.O. Patients: ONLY services authorized in writing by your HMO will per paid for, anything not authorized will be YOUR responsibility if services rendered are denied due to an IPA change or non-covered services, you are responsible for the balance.

Date:____________________ Signature________________________________(parent if minor)