**Sepideh Zahedy-Kapusta M.D.**
*Women and Family Clinic*
2094 W. La Habra Blvd.
La Habra CA 90631
562) 697-1001

## *Patient Information*

Last Name:_____ First Name: _____MI____

Birthdate:____/___/_____ SS#____/___/_____ Sex (circle One): Male / Female Driver's License#:_____

Married () Single () Divorced () Separated() Widow() Ethnicity/Country of Origin:_____

Address:_____City:_____ State: CA Zip:_____

Home Phone: ( )_____ Cell Phone: ( ) _____

Emergency Contact (name): _____ Relationship: _____ Phone#:_____

Employer:_____ Occupation:_____

Employer Address:_____ Phone # ( )_____

Pharmacy Information: (address and phone)_____

Primary Language spoken: _____ Need Interpreter? Yes/No

### *Responsible Party Information*

Last Name:_____ First Name: _____MI____

Birthdate:____/_____/_____ SS#_____/____/_____ Driver's License#:_____

Home Phone: ( )_____Relationship to Patient:_____

### Authorization to Release Information & Assignment of Benefits

I hereby authorize Dr. Sepideh Zahedy-Kapusta to release any medical information necessary to my Insurance Company or its agents in order to secure payments. I hereby assign Medical and /or surgical Benefits, Private Insurance, and any other Health Plan Benefit to Dr. Sepideh Zahedy-Kapusta. A copy of this assignment is considered as valid as the original.

Insurance Name:_____ID #_____Group #_____

### *Financial Responsibility*

I understand that I am financially responsible for all charges, whether or not paid by my Insurance, unless specifically exempted by my Insurance Company's Contract with Dr. Sepideh Zahedy-Kapusta. I certify that I have read the foregoing and have received a copy of it as the Patient, the patient's guardian, conserver or general agents. I agree and accept the above terms.

### *Authorization for Treatment*

I (and/or the undersign on behalf of the patient) voluntarily consent to allow Dr. Sepideh Zahedy-Kapusta and her staff to provide such evaluation and/or care and treatment as an out-patient on a continuing basis and as in-patient as necessary, as Dr.Sepideh Zahedy-Kapusta and her staff may decide is advisable and necessary.
I am advised that such treatment may include physical examination, laboratory procedures, x-ray examination, other office procedures, and as my status requires.
I understand that should I execute a durable power of attorney of Health Care or Advance Directive, I ***will*** provide an executed copy to my physician. I further understand that I will notify my physician of any changes in the Directive. **ADVANCE DIRECTIVE-PCP CARE ONLY.**
I understand that I will be informed about the course of my treatment.

*** A $25.00 charge for each form that requires Dr. Zahedy to complete and sign***

***By signing below, I certify that I have read and agree to all the terms and conditions stated above.***

**Patient/Guardian/ Conserver/General Agent's Signature** _____ **Date:**_____**Relation:**_____

## *Patient Questionnaire*

Please print the address of where you would like your billing statement and/or correspondence from our office to be sent if other than your home.

Please indicate if you want all correspondence from our office sent in a sealed envelope marked **"CONFIDENTIAL"** or by email: (please circle one)

YES NO

Patient Fusion- Email:_____

## *Consent for Purpose of Treatment, Payment and Healthcare Operations*

*Notice of Privacy Practices* - *HIPPA* - *Information is located in the Office Policy Handbook*

I consent to the disclosure of my protected health information by Dr. Sepideh Zahedy-Kapusta for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Dr. Sepideh Zahedy-Kapusta, I understand that diagnosis or treatment by Dr. Sepideh Zahedy-Kapusta may be conditioned upon my consents evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of this practice. Dr. Sepideh Zahedy-Kapusta is not required to agree to the restrictions that I may request. However, if Dr. Sepideh Zahedy-Kapusta M.D. agrees to a restriction that I request, the restriction is binding on Dr. Sepideh Zahedy-Kapusta.

I have the right to revoke this consent, in writing, at any time except when Dr. Sepideh Zahedy-Kapusta has taken actions in reliance of this consent.

My "protected health information" means health information, including my demographic information, collected from and created or received by my physician, another health care provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition that identifies me, or there is responsible basis to believe the information may identify me.

I understand I have the right to review Dr. Sepideh Zahedy-Kapusta's Notice of Privacy Practices prior to signing this document. Dr. Sepideh Zahedy-Kapusta's Notice of Privacy Practice has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Dr. Sepideh Zahdey-Kapusta. The Notice of Privacy Practices for Dr. Sepideh Zahedy-Kapusta is also provided in the front office. The Notice of Privacy Practices also describes my right and the duties with respect to my protected health information.

Dr. Sepideh Zahedy-Kapusta reserves the right to change the Privacy Practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling and requesting a revised copy sent in the mail or asking for one at the next appointment.

**Patient Initials**_____

## *Appointment Cancellation Agreement*

Patients who fail to show up to their appointments and who do not notify the practice in advance are costly to the practice and may prevent a sick individual who needs to be seen from getting a preferred appointment time. For the purposes of this policy, a **no-show** appointment is defined as an appointment which is missed by the patient without any advance notice.

If you are unable to keep your appointment, we ask that you kindly provide us with more than 24 hours notice. This courtesy will make it possible to give your appointment to another patient.

**This serves as notice that if you fail to give us a 24-hour notice of cancellation in the future, there will be a $25.00 cancellation fee billed to your account that is not covered by your insurance.**

_____
**Signature of Patient or Personal Representative**

_____
**Print Name**

_____
**Date**