SHARAM DANESHGAR, M.D.
Gastroenterology

Name: _____ **Date of Birth:** _____ **Age:** _____

Address: _____
Street *City* *State* *Zip Code*

SSN: _____ **Gender:** ☐ M ☐ F **Marital Status:** ☐Single ☐Married ☐Widowed ☐ Divorced

Home Phone: _____ **Cell:** _____ **E-Mail:** _____

Ethnicity / Race: ☐Caucasian ☐African American ☐Asian ☐Hispanic ☐American Indian ☐Other: _____
(Required by California Cancer Registry)

Employer: _____ **Occupation:** _____

Insurance Carrier/s: 1. _____ 2. _____

Name of Insured: _____ **Date of Birth:** _____ **Relationship:** _____

Person to be billed: ☐ Self ☐ Parent ☐ Spouse ☐ Other (Name) _____

Emergency Contact/s Name: _____ **Phone:** _____ **Relationship:** _____

Referring or Primary Doctor/s: _____

Please read and sign below:

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. **I acknowledge the possibility that a check and or checks may be sent directly to me instead of you, my provider. I understand this money is not mine even though the check may be written to me. I understand you are billing my insurance company as a courtesy to me but the money paid by the insurance company belongs entirely to you. I, therefore, agree to immediately, but certainly no later than 48 hours upon receipt of any such monies, forward this money directly to you. I will make no attempt to negotiate what portion I send to you. In any event, I acknowledge and agree that any charges for service rendered to me are my responsibility and I will pay all fees including any co-pays or deductibles, if applicable.**

X _____

Patient Signature or Financially Responsible Party Relationship to patient if not patient **Date**

2230 LYNN RD. # 300
THOUSAND OAKS, CA 91360
(805) 371-8400

Sharam Daneshgar,MD

Gastroenterology

DIPLOMATE OF THE AMERICAN BOARD OF
INTERNAL MEDICINE AD GASTROENTEROLOGY

HIPAA Privacy Rule Individual Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I,_____ understand that as part of my health care, **Sharam Daneshgar,** MD's originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with and understand the **Sharam Daneshgar, MD's** ***Notice of Privacy Practices*** provides a more complete description of the information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review **Sharam Daneshgar, MD's** Notice of Privacy Practices prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Parties to whom my PHI is authorized to be released:
*(Optional)*_____

_____

_____

_____

I understand that:

- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations by other covered entities;
- I may revoke this consent in writing at any time, except to the extent that **Sharam Daneshgar, MD** has already taken action in reliance thereon.

[ ] Accepted [] Denied

Patient Authorization for Office Procedures

Our office is 'HIPPA Compliant" and our staff has been trained in the "HIPPA Privacy Act". We will do everything we can to protect your Patient Health Information (PHI). However, our office is designed before the HIPPA Law, so please be respectful of other patients' privacy.
We are required by the insurance companies to prove that you were here in our office on the date of service that we are billing for. Our office procedure, to prove that you were here, is that we have daily sign in sheet which you sign at the time of your appointment.

1. **How would you like us to address you, by your first name or last name?**

   _____

2. **It is our office procedure that we call you regarding medical issues. If you are not home, whom may we leave the message with?**

   _____

3. **If no one is at home to take our call, may we leave a message on your answering machine?**
   Yes No

I agree to all of the above office procedures of Sharam Daneshgar, M.D. and I give my authorization to all of the above-mentioned procedures.

Acknowledgement of Receipt of Information Practices Notice(§164.520(a))

I understand that as part of my health care, Sharam Daneshgar, M.D. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand **Sharam Daneshgar, MD's**, *Notice of Privacy Practices* which provides a complete description of the uses and disclosures of my health information.

I understand that:

- I have the right to review **Sharam Daneshgar, MD's** *Notice of Privacy Practices* prior to signing this acknowledgement;
- That **Sharam Daneshgar, MD**, reserve the right to change his *Notice of Privacy Practices* and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness:

_____

Printed Name of Individual or Legal Representative Witness:

_____

Date: _____

Medical History Form

Patient Name: _____ **DOB:**_____

What is the reason for your visit? ☐**Colonoscopy Consult** ☐**Endoscopy Consult** ☐**Other**

1. From the list of symptoms below, please <u>MARK</u> any that you have experienced recently.

□ Nausea	□ Vomiting	□ Heartburn	□ Pain when swallowing
□ Black stools	□ Rectal pain	□ Constipation	□ Abdominal pain
□ Rectal bleeding	□ Loss of appetite	□ Diarrhea	□ Weight loss
□ Difficulty swallowing (food gets stuck)		□ Change in bowel habits	

Other: _____

2. Allergies/ Sensitivities to Medication: _____

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3. Medication List (Prescription Only):

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

4. Social History: ***Tobacco/Cigarette/Vaping:*** ☐No ☐Light ☐Heavy ☐Social ☐Occasional

Alcohol (Wine, Beer, Hard Liqour) ☐No ☐Light ☐Heavy ☐Social ☐Occasional

5. Family History: **(Information on major medical conditions, causes of death, age at disease diagnosis, age at death):**

_____

_____

_____

Patients Signature: _____ **Date:** _____