Comprehensive Rheumatology Center

Nazanin Firooz, MD

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818-598-0000
Fax: 818-598-0500

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

Acknowledgement of Receipt of Notice of Privacy Practices: _____ (Initial)
(This notice describes how medical information about you may be used and disclosed and how you can get access to this information). I have received a copy of the Notice of Privacy practices.

Financial Responsibility: **_____** (Initial)
I understand that I am liable/responsible for all charges, including but not limited to copayments and annual deductibles. If I am found to be ineligible under the terms of my health plan agreement, or if my insurance carrier deems the service as "non-covered services", I understand that I am liable for the charges for services rendered. I understand that payment is required within 30 days of receiving a bill from this office and that failure to pay may result in my account being placed in collections.

I irrevocably assign to the doctor all payments for medical services rendered to myself or my dependents.
Returned checks: **A $35.00 charge will be applied to all returned checks for insufficient funds.**

Cancellation Policy: **_____** (Initial)
I understand that my appointment is a time that is reserved for me. In case I am not able to make it to my appointment for any reason, I agree to notify the office immediately. **I understand that failure to cancel my appointment at least 2 business days before may result in a $50.00 fee**.

Review of Results Over the Phone: _____ (Initial)
Unless otherwise specified, results of laboratory studies, x-rays, and other diagnostic studies completed after my initial visit will not be discussed over the phone. This is to ensure that I am provided with a thorough and complete care. Since rheumatologic diseases are often complex, interpretation of such studies are often not possible without a re- evaluation during the follow-up visit. A positive result may have serious implications and will require a full explanation of the disease and design of a treatment plan unique to me. In case of negative results, further investigation is needed to determine the cause of my symptoms given the negative findings. Should I chose not to have a followup visit, I can get a copy of my results after signing a waiver.

Whom can we discuss your medical information with:

☐ No one ☐ Spouse ☐ Other family: _____ ☐ Other: _____

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE.

_____ _____
Signature Date

_____
Name

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian

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