MODERN ORTHOPEDIC
SPINE SPECIALISTS

PAYMENT OF SERVICE / PAGO de SERVICIOS

I also authorize payment to be made directly to Armen Oganesian, D.O., MPH, for the medical and/or surgical benefits, if any, otherwise payable to me for service rendered. I realize this may not represent the full payment for service rendered and I will be responsible for the balance due.

Tambien autorizo a que se haga pago directamente a Armen Oganesian, D.O., MPH, para beneficios medicos y quirurgicos si hay alguna, o de que otra manera se me pagaran a mi por los servicios rendidos. Yo entiendo que esto no representa pago complete por servicios ofrecidos y yo sere responsible por el balance que se debe.

_____ _____

Print Name/Signature Date

MOSS
MODERN ORTHOPEDIC
SPINE SPECIALISTS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To: _____

_____

Doctor or Hospital & Address

I hear by authorize and request you to release

To: _____

_____

Doctor or Hospital & Address

the complete medical records in your possession, concerning my illness and/or treatment during the period from _____ to _____.

Print Name _____ Signed _____

D.O.B. _____ Date _____

Witness _____

Armen Oganesian, D.O., MPH

250 Lombard Street, First Floor, Thousand Oaks, CA 91360 • (805) 370-0748

Federal and State Laws require that this office keep all x-rays that we take on file as part of the patient's permanent records. We take digital x-rays and store them electronically. If a copy of your x-rays is requested, a charge of $15.00 will apply and a compact disc will be provided to you.

I have read the above and understand the policy of this office

_____ _____

Initials Date

If you need to have a procedure done, Dr. Oganesian has privileges at Los Robles Regional Medical Center and Thousand Oaks Surgical Hospital. Dr. Oganesian does surgeries at both of these locations.

I have read the above and understand the policy of this office

_____ _____

Initials Date

HIPAA

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Armen Oganesian, D.O., MPH or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may request and receive a copy of the notice at any time.

You may request a restriction on the use or disclosure of your protected health information. Armen Oganesian, D.O., MPH may or may not agree to restrict the use or disclosure of your protected health information. Use or disclosure of protected information in violation of an agree upon restriction will be a violation of federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Armen Oganesian, D.O., MPH reserves the right to modify the privacy practices outlined in this notice.

Disclosure to Specified Individuals

I give my permission for my protected health information to be disclosed for the purposes of communication of results, findings and care decisions to my family members and others listed below.

Name: _____ Name: _____

Name: _____ Name: _____

I have reviewed this consent form and give my permission to Armen Oganesian, D.O., MPH to use and disclose my health information in accordance with it.

_____ _____

Initials Date

I, _____, have read, reviewed, and understand the above office policies.

_____ _____

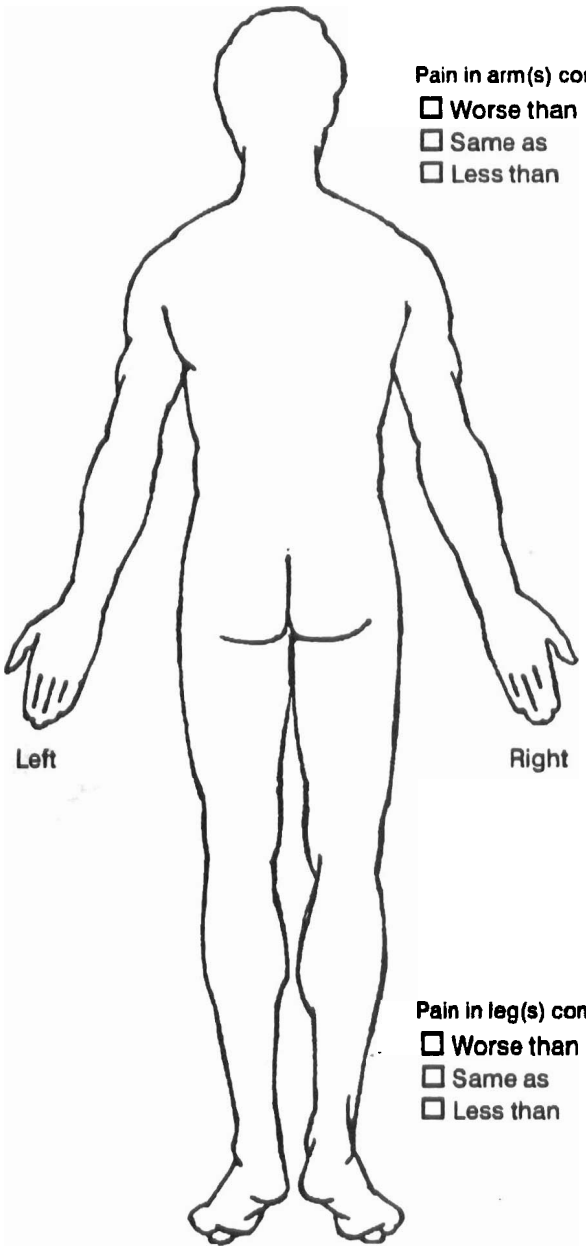
Signature (Patient/Parent/Guardian) Date

PATIENT PAIN DRAWING

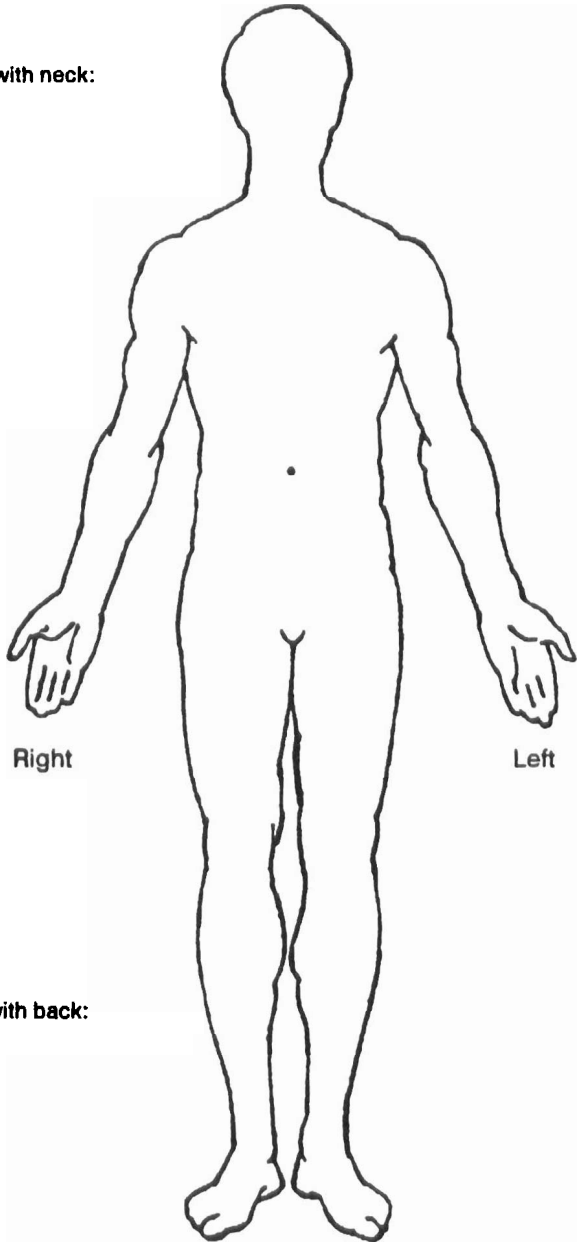
Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas.

Aching	Numbness	Pins and needles	Burning	Stabbing	Other
▲ ▲ ▲	= = =	o o o	x x x	/ / /	● ● ●

Back



Front



Pain in arm(s) compared with neck:

- ☐ Worse than
- ☐ Same as
- ☐ Less than

Pain in leg(s) compared with back:

- ☐ Worse than
- ☐ Same as
- ☐ Less than

Are you presently working? Yes ____ No ____ Patient Phone No. _____

If working: Employer _____ Occupation _____

I have disclosed all prior injuries, accidents and orthopedic problems to the best of my recollection.

Patient Signature _____ Date _____

* **EMAIL ADDRESS TO CONFIRM APPT.** _____