Emily Iker, M.D.
2021 Santa Monica Blvd., Suite 620E
Santa Monica, CA 90404
(310) 829-7472
Patient Information Form

PATIENT'S FULL NAME: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: (_____) _____ CELL PHONE: (_____) _____

DATE OF BIRTH: _____ EMAIL: _____

DRIVER'S LICENSE: _____

MARITAL STATUS: ( ) SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOWED **SEX:** M ( ) F ( )

NAME OF EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ WORK PHONE #: _____

REFERRING PHYSICIAN: _____ PHONE #: (_____) _____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____

RELATIONSHIP TO PATIENT: _____ PHONE #: (_____) _____

INJURY AND CHIEF COMPLAINT: _____

ANY KNOWN ALLERGIES: _____

WILL YOU BE PAYING WITH: CASH: _____ CHECK _____ INS. _____

TYPE OF INSURANCE: _____

I understand that I am financially responsible for all charges for services to me not covered by the insurance, including the balance remaining after payment of possible insurance benefits.

Assignment of Benefits and Release of Information: I hereby authorize payment directly to Emily Iker, M.D. for services rendered. I also authorize Emily Iker, M.D. to release to my insurance carrier any information needed for filing an insurance claim.

DATE: _____ SIGNATURE: _____

Medical History

Do you have a personal physician? **Y N**

Physician's Name: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? **Y N**

Please explain:

_____

Weight:_____Height:_____ Blood Pressure : _____

Current Pain Level:____ / 10

Sexual Orientation: **straight (heterosexual)** ; **bisexual** ; **gay** ; **lesbian** ; **Prefer not to disclose**

Gender: **Male Female Prefer not to disclose**

Have you ever had any of the following diseases or medical problems?

Y N Advanced Directive
Y N Implants
Y N Tobacco use
Y N Abnormal bleeding/ Hemophilia
Y N AIDS
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/ Joints/ Valves
Y N Blood Transfusion
Y N Blood clots
Y N Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N DifficultyBreathing
Y N Frequent Headaches
Y N Heart Attack/Surgery
Y N Heart Murmur
Y N Hepatitis

Y N High Blood Pressure
Y N HIV
Y N Hospitalized For Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Pacemaker
Y N Radiation Treatment
Y N Rheumatic/ Scarlet Fever
Y N Seizures
Y N Shingles
Y N Stroke
Y N Thyroid Problems
Y **N** Cancer
Please specify:

_____

Please List any other serious medical condition(s) that you have ever had:

_____

List any allergies:

_____

On going medical conditions:

_____

List any medications you are currently taking:

_____

EMILY IKER, M.D.
PHYSICAL MEDICINE AND REHABILIATION

AUTHORIZATION TO PAY INSURANCE BENEFITS

It is your responsibility to read this Insurance Authorization Form ***carefully*** prior to signing it. You are FULLY responsible for any portion of your bill not covered by your insurance company.

1. BILLING: I understand that all services are billed through the rendering physician providing the services. As a courtesy to me, a claim will be sent on my behalf to my insurance company for all services provided. These services are billed separately from those of any other physician I may see on the same day.

2. COVERAGE: Charges for the services provided after initial consultation by Emily Iker, M.D. are considered ***physical therapy*** and insurance coverage may be affected if I am receiving physical therapy elsewhere. I agree that I am financially responsible for any and/or all charges not covered by my insurance for the services rendered to me.

3. DISCOUNTS: Emily Iker, M.D. does not give discounts, nor will we write off any portion of your bill that is not covered by your insurance provider. Such write-offs may constitute insurance fraud and may be illegal.

4. INSURANCE DISPUTES: If you have a dispute with your insurance company regarding the services provided by Emily Iker, M.D. or any of your medical billing, you may seek advice from the STATE OFFICE of the INSURANCE COMMISIONER. The consumer hotline number for Los Angeles is (213) 287-8921.

5. CANCELLATION POLICY: In order to avoid being billed in full for scheduled services, all cancellations require AT LEAST ONE FULL WORKING DAY (at least 24 hours) advanced notification. Monday appointments must be cancelled on the prior Friday as we are closed weekends. YOU WILL BE BILLED $100 FOR A MISSED APPOINTMENT SINCE INSURANCE PROVIDERS DO NO REIMBURSE FOR THIS CODE.

I, (Print Name)_____, acknowledge that I have read paragraphs1-5 and that I understand the contents of this authorization. I agree to the terms and conditions of this authorization. By my signature below, I hereby authorize my insurance company to pay directly to my medical/health insurance policy for all professional services rendered to me. I agree that I am financially responsible for any and all chargers not covered in the terms of this assignment.

Signature: _____ Date: _____

2021 Santa Monica BOULEVARD, Suite 620 Santa Monica, CALIFORNIA 90404
TEL (310)829-747:2. F.AX (310)829-2286 IKER@LYMPHEDEMACENTER.COM
www.lymphedemacenter.com

Emily Iker, M.D.

2021 Santa Monica, Suite 620 E

Santa Monica, Ca 90404

310-829-7472

PRACTICE INFORMATION AND DISCLOSURE STATEMENT

Billing and Payment Information

If you are with a different insurance company who I am not contracted with, you will pay my cash patient fee at the end of each session, and you can then submit a claim to your plan and receive full or partial reimbursement.

- **If the insurance refunds me directly I will then refund you the amount that the insurance gave to me, and NOT the full amount you paid for cash visit.**
- **I only accept cash and checks.**

AUTHORIZATION by signing below, you attest to the following: "I have been given the above information. I acknowledge fully that I am responsible for all balances on my account, regardless of whether or not I am insured."

Patient's name (printed) _____ Date _____

Patient signature _____

Emily Iker, M.D.
Lymphedema Center
2021 S. Santa Monica Blvd. Suite 620 E
Santa Monica. CA 90404

Photo Consent and Release Form

Without expectation of compensation or other remuneration, now or in the future, I hereby give my consent to Dr. Emily Iker, to be photographed for the advancement of medical purposes, including teaching, research, and education.
This consent includes, but is not limited to:

a.) Permission to photograph, interview, film, tape, or otherwise make a video reproduction

b.) Permission to use quotes from the interview(s) (or excerpts of such quotes), the film, photograph(s), tape(s) or reproduction(s) of me, and/or recording of my voice, in part or in whole, in its publications, in newspapers, magazines and other print media, on television, radio and electronic media (including the Internet), in theatrical media and/or in mailings for educational and awareness.

This consent is given in perpetuity, and not require prior approval by me.

Patient Name: _____

Signature: _____

Date: _____

Consent For Minors

The below signed parent or legal guardian of the above-named minor child hereby consents to and gives permission to the above on behalf of S11Ch minor child.

Signature of Parent
or Legal Guardian: _____ Print Name: _____

_____

The following is required if the consent form has to be read to the parent/legal guardian:
L certify that I have read this consent form in full to the parent/legal guardian whose signature appears above.

_____ _____

Date SignatureofOrganizational Representative orCommunity Leader

PRIVACY POLICIES AND PRACTICES

HIPAA : SUMMARY NOTICE OF PRIVACY PRACTICES

We are required by federal law to provide you with a Notice of Privacy Practices that describes how medical information that we maintain about you may be used or disclosed. The Notice describes how, when, and why we use and disclose medical information about you, and provides a description of your rights and our obligations under federal and state privacy laws.

USES AND DISCLOSURES

We are permitted to use and disclose your health information on under a variety of circumstances. Sometimes we must obtain your authorization before we use or disclose that information, but on other circumstances we may use your information without your authorization and without informing you of the use or disclosure. Some of the reasons that we may use or disclose your information include:

- To provide information about your health condition to other health care providers who may treat you;
- To provide information about the treatment that we provided in order to obtain payment from your health plan;
- To report a communicable disease, or meet other legal reporting requirements, or
- To comply with a court order requiring the disclosure of your medical record

These examples are merely illustrative. For a full description of the uses and disclosures that we are permitted to make, please consult the full Notice of Privacy Practices.

YOUR RIGHTS

While the records that we maintain about your belong to us; under the federal privacy law you have a variety of rights with respect to the information maintained in those records. For instance, you have the right to access and receive a copy of the medical information we maintain about you and to request that we amend any of the information that you believe is incomplete or incorrect. Also, you may request that we provide you with a list of disclosures that we have made of your medical information. All of these rights are subject to some exceptions that are described in full in the Notice of Privacy Practice.

ACKNOWLEDGEMENT

You will be asked to sign an acknowledgement of your receipt of this Notice of Privacy Practices. However, your receipt of care and treatment is not conditioned upon your signing the acknowledgement form.

OUR OBLIGATIONS

We are required to provide you with our Notice of Privacy Practices and to abide by its terms. We may change the Notice from time to time. Our full Notice of Privacy Practices is also available from the front desk staff of your doctor's office. Please read the full notice carefully. If you have any questions or require additional information, please contact our office (310) 829-7472, or via e-mail at iker@lymphedemacenter.com.

ACKNOWLEDGMENT OF RECEIPT

I hereby acknowledge that I have received a copy of the Lymphedema Center of Santa Monica Notice of Privacy Practices.

_____ _____

Signature of Patient or Patient's Representative Date

_____

Printed Name of Patient/Patient's Representative

_____

Relationship to the Patient

Lower Extremity Functional Index

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for each activity.

Today, do you or would you have any difficulty at all with:

(Circle one number on each line)

Activities	Extreme Difficulty or unable to perform activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
a. Any of your usual work, housework or school activities.	0	1	2	3	4
b. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
c. Getting into or out of the bath.	0	1	2	3	4
d. Walking between rooms.	0	1	2	3	4
e. Putting on your shoes or socks.	0	1	2	3	4
f. Squatting.	0	1	2	3	4
g. Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
h. Performing light activities around your home.	0	1	2	3	4
i. Performing heavy activities around your home.	0	1	2	3	4
j. Getting into or out of a car.	0	1	2	3	4
k. Walking 2 blocks.	0	1	2	3	4
l. Walking a mile.	0	1	2	3	4
m. Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
n. Standing for 1 hour.	0	1	2	3	4
o. Sitting for 1 hour.	0	1	2	3	4
p. Running on even ground.	0	1	2	3	4
q. Running on uneven ground.	0	1	2	3	4
r. Making sharp turns while running fast.	0	1	2	3	4
s. Hopping.	0	1	2	3	4
t. Rolling over in bed.	0	1	2	3	4
COLUMN TOTALS					

Score variation ± 6 LEFTS points
MDC & MCID = 9 LEFS points

Score_____/80

THE UPPER EXTREMITY FUNCTIONAL INDEX (UEFI)

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your upper limb problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

(Circle one number on each line)

	Activities	**Extreme Difficulty or Unable to Perform Activity**	**Quite a Bit of Difficulty**	**Moderate Difficulty**	**A Little Bit of Difficulty**	**No Difficulty**
1	Any of your usual work, housework, or school activities	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities	0	1	2	3	4
3	Lifting a bag of groceries to waist level	0	1	2	3	4
4	Lifting a bag of groceries above your head	0	1	2	3	4
5	Grooming your hair	0	1	2	3	4
6	Pushing up on your hands (eg from bathtub or chair)	0	1	2	3	4
7	Preparing food (eg peeling, cutting)	0	1	2	3	4
8	Driving	0	1	2	3	4
9	Vacuuming, sweeping or raking	0	1	2	3	4
10	Dressing	0	1	2	3	4
11	Doing up buttons	0	1	2	3	4
12	Using tools or appliances	0	1	2	3	4
13	Opening doors	0	1	2	3	4
14	Cleaning	0	1	2	3	4
15	Tying or lacing shoes	0	1	2	3	4
16	Sleeping	0	1	2	3	4
17	Laundering clothes (eg washing, ironing, folding)	0	1	2	3	4
18	Opening a jar	0	1	2	3	4
19	Throwing a ball	0	1	2	3	4
20	Carrying a small suitcase with your affected limb	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points **SCORE:_____/80**

Source: Stratford PW, Binkley, JM, Stratford DM (2001): Development and initial validation of the upper extremity functional index. Physiotherapy Canada. 53(4):259-267.