Dr. Morvarid Yousefi, M.D.
6550 Rock Spring Drive
Suite 155
Bethesda, MD 20817

Office: (301) 564-6022
Fax: (301) 564-3738

INFORMED CONSENT AND OUT OF NETWORK WAIVER FORM

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

Physician Name: Dr. Morvarid Yousefi, M.D.

Insurance Carrier: _____

Your signature below signifies that you clearly understand the following:

I, (listed above) authorize Dr. Morvarid Yousefi, M.D. to evaluate and begin treatment and procedures deemed appropriate to improve my condition. It is recognized that the practice of medicine is not an exact science and, as such, no guarantees are made by Dr. Yousefi as to the results of treatments or interventions performed. I am advised that I have the right to a full explanation of any treatment or procedure utilized. I understand that I have the right to refuse treatment; but in doing so, I also understand that the desired outcome of my treatment program may be affected.

The provider you are seeing is NOT a participating provider with any health insurance. I understand that my health insurance will not be billed by Dr. Yousefi and that I will be responsible for the full payment of my bill at the time of service. I understand that upon request, I will receive a bill from Dr. Yousefi for my services that I can submit to my health insurance company for reimbursement if I choose to do so. Dr. Yousefi does not guarantee that my health insurance company will reimburse me for my services. It is the patient's responsibility to contact their insurance and check for out-of-network benefits and whether or not pre-authorization is required.

I hereby certify that I have read the contents of this Informed Consent and Out of Network Waiver. I may request a signed copy of the Agreement and the Informed Consent. I agree to be bound by the reasonable rules and regulations adopted by Dr. Yousefi in connection with the use of its facilities and equipment. I agree that the foregoing obligations shall be binding of me personally, as well as upon my family and my heirs, executors, administrators and assigns.

Cancellation Policy: In order to provide quality medical care in a timely manner, we have implemented a no-show and cancellation policy. This policy allows us to better utilize available appointments for our patients in need for care. All no-shows or failure to notify the office within 24 hours of their scheduled appointment time will result in a $200.00 cancellation fee.

Patient Signature: _____ **Date:** _____

Parent Signature:
(If Patient is under age of 18) _____ **Date:** _____

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Morvarid YOUSEFI
PHYSIATRIST

PATIENT DEMOGRAPHICS FORM

Patient Name: _____ **Sex:** _____ **Date:** _____

Date of Birth: _____

Height: _____ **Weight:** _____ **Marital Status:** _____

Address: _____

_____

Cell Phone: _____ **Home Phone:** _____

Work Phone: _____ **Email:** _____

Referring Physician: _____ **Phone:** _____

Primary Care Physician: _____ **Phone:** _____

Work Status: Employed Retired Unemployed
Disability: Prior to Injury/Complaint Disability: Due to Injury/Complaint

Employer Name: _____ **Phone:** _____

Address: _____

_____

Emergency Contact: _____ **Phone:** _____

Relationship to Patient: _____

Address: _____

_____

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Morvarid YOUSEFI
PHYSIATRIST

PATIENT EVALUATION FORMS

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

Chief Complaint: _____

_____

Is your chief complaint the result of an injury? (circle one): Yes No

Date of injury or when chief complaint began: _____

Are you receiving or filing for any of the following with regard to your complaint? (circle one):

Worker's Compensation Disability Lawsuit None

What caused your injury or chief complaint?

- ❑ Fall
- ❑ Lifting
- ❑ Throwing
- ❑ Reaching
- ❑ Twisting
- ❑ Fighting
- ❑ Collision/Contact
- ❑ Pulling
- ❑ Other:

Check any symptoms you are currently experiencing:

- ❑ Pain
- ❑ Weakness
- ❑ Instability
- ❑ Restricted Motion
- ❑ Other:

Please provide a brief description of where the injury occurred and what symptoms you experienced at the time of the injury or chief complaint (i.e. swelling, popping, fracture)

_____

_____

Have you received prior treatment for the injury or chief complaint? (circle one): Yes No

If yes, please specify: _____

Allergies: Please list any allergies and your reactions that you are currently aware of:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

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Medications: Please list any medications you are currently taking, both prescription & over-the-counter

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

REVIEW OF SYMPTOMS

Please check any of the following that you are currently experiencing:

General:
- ❑ Fever
- ❑ Chills
- ❑ Weight Loss
- ❑ Fatigue
- ❑ Weakness

Head/Ears/Nose/Throat:
- ❑ Headaches
- ❑ Hearing Loss
- ❑ Ear Pain
- ❑ Congestion
- ❑ Sore Throat

Eyes:
- ❑ Blurred Vision
- ❑ Double Vision
- ❑ Eye Pain

Cardiovascular:
- ❑ Chest Pain
- ❑ Palpitation
- ❑ Shortness of Breath
- ❑ Leg Swelling

Respiratory:
- ❑ Cough
- ❑ Coughing Up Blood
- ❑ Mucus Production
- ❑ Shortness of Breath
- ❑ Wheezing

Musculoskeletal:
- ❑ Neck Pain
- ❑ Back Pain
- ❑ Joint Pain

Genitourinary:
- ❑ Painful Urination
- ❑ Urgency
- ❑ Frequency

Gastrointestinal:
- ❑ Heartburn
- ❑ Nausea
- ❑ Vomiting
- ❑ Abdominal Pain
- ❑ Diarrhea
- ❑ Constipation

Please check any of the following that best describe the character of your pain at the time of injury or onset of chief complaint:

- ❑ Aching
- ❑ Throbbing
- ❑ Shooting
- ❑ Stabbing
- ❑ Gnawing
- ❑ Penetrating
- ❑ Numb
- ❑ Sharp
- ❑ Tender
- ❑ Burning exhausting
- ❑ Nagging
- ❑ Unbearable

Please check any of the following actions that make the pain better:

- ❑ Rest
- ❑ Medication
- ❑ Ice
- ❑ Heat
- ❑ Sitting
- ❑ Lying Down
- ❑ Walking
- ❑ Standing
- ❑ Nothing in particular
- ❑ Other: _____

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Please check any of the following actions that make the pain worse:

- ❑ Sitting
- ❑ Standing
- ❑ Lying Down
- ❑ Walking
- ❑ Exercising
- ❑ Activity in general
- ❑ Stopping/bending
- ❑ Nothing in particular
- ❑ Other: _____