44 Sylvan Ave. Suite 2D Englewood Cliffs, NJ 07632
www.drannkim.com
T 201-585-0957 F 201-585-0902

ABOUT YOU

Patient Name : _____ **DOB :** _____/_____/_____ **SS# :** _____

What you prefer to be called : _____ **Who can we thank for your referral? :** _____

Home Address : _____

Sex : Male / Female **Occupation :** _____ **Email Address :** _____.com

Status : ○Single ○Married ○Divorced ○Widowed **Name of Spouse :** _____ **# of Children :** _____

Home Ph # : (_____)_____-_____ **Cell Ph # : (_____)_____-_____** **Work Ph # : (_____)_____-_____**

Pharmacy Info : _____ **City, State** _____ **Ph # : (_____)_____-_____**

EMERGENCY CONTACT

Who should we contact in the event of an emergency? _____

Relationship with person stated above : _____ **Emergency contact :** (_____)_____-_____

INSURANCE

Policy Holder Name : _____ **Policy Holder DOB :** _____/_____/_____**Ph # : (_____)_____-_____**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 HIPAA, I have certain rights of privacy regarding my protected health information. I understand that this information can and will be used to: 1. conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. 2. obtain payment from third party payers. 3. conduct normal healthcare operations such as quality assessments and physician certifications. I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Family members or others you authorize us to discuss your protected health information with :

NAME : _____ **Relation to patient :** _____**Ph # : (_____)_____-_____**

ACCOUNT INFORMATION

I hereby authorize the release of any information necessary to file a claim with my insurance company. I further authorize and direct my insurance company to pay the proceeds of any such claim directly to Ann Kim MD PC and assign any right I may have to such funds to Ann Kim MD PC. In the event that I receive payment from my insurance company, I acknowledge that the funds belong to Ann Kim MD PC, and agree to promptly turn any such funds over to Ann Kim MD PC. I acknowledge and understand that I am personally responsible for all services rendered to me by Ann Kim MD PC, and that I am personally responsible for payment for any such services not covered by my insurance. I further acknowledge that no representations have been made by Ann Kim MD PC regarding any insurance coverage for services rendered or to be rendered and realize that any such coverage is controlled by whatever agreement I have with my insurance company. I further authorize Ann Kim MD PC to render treatment and/or medical advice for the betterment and well being of myself and/or my dependent.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Name : _____ **Patient Signature :** _____ **Date :** ____/____/____