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 :** ____/____/____

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NAME : _____

Patient Financial Policy

Thank you for choosing Joy Internal Medicine for your health care needs. The patient financial policy has been developed to assist in answering your questions regarding patient and insurance responsibility for services rendered. Your understanding of and compliance with our patient financial policy is important. Please read the policy below and ask the staff any questions you may have and sign as indicated. The original will be maintained in your file and a copy may be provided to you upon your request.

1. PROOF OF INSURANCE: All patients must complete our patient information form before seeing the physician. If you are not insured by a plan that we participate with, payment in full is expected at each time of service. It is your responsibility to ensure that we have your correct information and an up-to-date copy of your insurance card.

2. UPDATED CHANGE OF INFORMATION & COVERAGE: We will ask you to update this whenever you have a change in address, employment, insurance, etc. However, it is your responsibility to make us aware of these changes and if you fail to provide us with the correct updated information, you will be responsible for the entire cost of the services rendered and immediate payment will be expected.

3. CO-PAYMENTS, DEDUCTIBLES & CO-INSURANCE: All co-payments, deductibles & co-insurance must be paid at the time of service. Payment of your copayments, deductibles & co-insurance is part of your contract agreement with your insurance plan. Our failure to collect payment may be a violation of billing compliance and may be considered as an act of fraud by your insurance plan.

4. NON-COVERED SERVICES: Please be aware that some or perhaps all of the services you receive may not be covered or considered reasonable or necessary by your insurance plan. If you elect to have these services, you will be asked to sign a waiver and payment in full at the time of service will be expected.

5. PRIMARY CARE SELECTION: Some plans require patient to designate primary care physician before seeing Dr Kim. It is patient's responsibility to find out if your plan requires this and must be done prior to visit. If claim is denied due to this reason, it is patient's responsibility.

6. CLAIMS SUBMISSION: We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance plan may request information directly from you. Your failure to timely comply to your insurance plan's request may result in your claim denial and if so, will result in our seeking full reimbursement from you for services rendered; even if we are a participating provider with your plan. Your insurance benefit is a contract between you and your insurance plan.

7. SELF-PAY: If you do not have valid health care coverage, you will be considered as self-pay. Payment in full is due at the time of service.

8. NON-PAYMENT: If your account is over 60 days past due, you will receive a statement indicating that you have 30 days to pay your account in full. Partial payments will not be accepted unless you have contacted our office and otherwise negotiated. Please be aware that if a balance remains unpaid, we will turn your account over to a collection agency after the 90th day past due.

9. RETURNED CHECKS: A returned check fee of $30 will be added to your account for every check returned for insufficient funds, stopped payment or closed accounts. After the second occurrence, only cash or credit card payments will be accepted.

11. NO SHOW POLICY: We respectfully request a minimum of 24 hours advance notice for office visit and procedure appointment cancellation. A fee of $20 for a missed office visit without a notification will be required and enforced. If you miss 3 or more visits without canceling or rescheduling 24 hours in advance you may be dismissed from our practice

12. Medication Request: We do not provide prescription for a new medication without an office visit. However, in some urgent cases, medication can be faxed to your pharmacy and patient will be charged an office visit co-pays. (Patients without $0 copay will be charged with $20.)

*****Knowing your insurance benefits is your responsibility. Please contact your insurance plan with questions you may have regarding your coverage*****

This is an agreement between Joy Internal Medicine and the patient/responsible party signed below. By executing this agreement, you are agreeing to pay for all services that are received.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINE.

Patient's Name: _____

Patient's Signature: _____

Date: _____