Sun Kim M.D.

5832 Beach Blvd Suite #213 Buena Park, CA 90621 Phone (714)752-6835 Fax (714)752-6842

Patient Demographics

____ Male/Female

Legal Last Name Legal First Name Legal Middle Name Birth Date Gender

____

Permanent Address Apt # City State Zip

____

Home Phone # Cell Phone # Race/Ethnicity

____

Social Security # E-mail Address Language

Emergency Contact Information

Single / Married / Divorced / Widowed ____

Marital Status (Circle One) Spouse Last Name Spouse First Name

____

Emergency Contact Name Emergency Contact Phone # Relationship

____

How did you hear about us? (Doctor, friend, newspaper, etc)

Primary care physician & Pharmacy Information

____

Physician Name Office Location Office Phone #

____

Pharmacy Name Pharmacy Address Pharmacy Phone #

Patient Health History

CHIEF COMPLAINT ____

ALLERGIES (If you have allergies, please write them down)

____

IF **NO** allergies, check here ☐

MEDICATIONS (Every medication that you are currently taking)

____

____

IF **NO** medication, check here ☐

It is the patient's responsibility to pay deductibles, co-insurances/co-pays on the day of service, and to pay any other balance not paid for by insurance. If we are filing claim, we will allow forty-five days from the filing date for the carrier to process your claim and make payment. If an insurance payment is not received within this time frame, we will notify you to clear your account. Insurance filing is done as a courtesy to you and does not dismiss your responsibly to pay for services. Self-pay patients must pay for services the day on which they are rendered.

I understand that I am financially responsible for all charges incurred whether or not paid by an insurance carrier.

I the undersigned, represent that I have insurance coverage and do hereby authorize them to pay and assign directly to Sun Kim M.D. Inc. all surgical and/or medical benefits, if any. Otherwise payable to me for services as described on the attached forms herewith, but not to exceed the charges for those services. I understand that I am financially responsible for all charges whether or not they are paid by said insurance company. I hereby authorize said assignee to release all information necessary to secure payment of said benefits.

X ____________________________________ X ____________________________________

Signature Date

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MEDICAL HISTORY

Do you now, or have you had any problems related to the following symptoms: Please check if you do have that symptom or condition.

Genitourinary History
__ Blood in Urine
__ Bladder Cancer
__ Incontinence
__ Erectile Dysfunction
__ Gout
__ Kidney Stones
__ Kidney Cancer
__ Prostatitis
__ Benign Prostatic Hyperplasia

Personal History
__ Diabetes
__ Hepatitis
__ High Cholesterol
__ High Blood Pressure
__ Low Blood Pressure
__ Stroke
__ Asthma
__ Bronchitis
__ Renal Disease
__ Thyroid Disorders
__ Chronic Urinary tract infection
__ Arthritis
__ Anemia
__ HIV
__ Others: ___________________

Family History
__ Prostate Cancer
__ Renal Cancer
__ Bladder Cancer
__ Testicular Cancer
__ Heart Disease
__ Stroke
__ High Blood Pressure
__ Diabetes
__ Kidney Disease
__ Bladder Stones
__ Others: ___________________

Surgeries
__ Tonsillectomy
__ C-Section
__ Knee Surgery
__ D&C
__ Laparoscopy
__ Appendectomy
__ Hysterectomy
__ Hernia Repair
__ Gallbladder Surgery
__ Vasectomy
__ Colonoscopy
__ Tubal Ligation
__ Shoulder Surgery
__ Other: ____________________

Social history

Tobacco Use
__ Never Smoke
__ Former Smoke
__ Current Every day Smoker
__ Current Some day smoker

Alcohol Use
__ Yes (Heavy, Light)
__ No
__ Prior History of abuse

Caffeine Use
__ 1-2 cups/day
__ Over 3cups/day
__ No

Marijuana Use
__ Yes
__ No

General
__ Fatigue
__ Night sweats
__ Chills
__ Weight Gain
__ Weight Loss

Head
__ Chronic headache
__ Head Injury

Eye
__ Vision Loss
__ Double Vision

Ear, Mouth, Nose and Throat
__ Ear Ringing
__ Nosebleeds
__ Hoarseness
__ Decreased Hearing

Respiratory
__ Chronic Cough
__ Wheezing
__ Difficulty Breathing

Heart
__ Chest Pain
__ Murmur
__ Palpitations

Gastrointestinal
__ Constipation
__ Diarrhea
__ Vomiting
__ Rectal Bleeding
__ Nausea

Muscular-skeletal
__ Back Pain
__ Joint Pain
__ Joint Swelling
__ Muscle Weakness
__Muscular Pain

Skin
__ Ulcers
__ Rash
__ Itching
__ Lesions

Neurological
__ Dizziness
__ Seizures
__ Tremor

Psychiatric
__ Anxiety
__ Depression

Patient name:
DOB:

__ Mood Changes

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Patient Financial Responsibility

As a courtesy to our patients we have enrolled in numerous insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify insurance coverage and bill your insurance company correctly. However, it is not possible for us to keep track of all the individual requirements of each plan.

It is the responsibility of each patient to know the details of his or her Insurance plan in addition to any lapses in insurance coverage. Any chargers that occur as a result of insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. Unfortunately, if you do not inform us of special requirements required by your insurance plan and we order medically necessary service, such as lab work, hospitalization, or supplies that are not covered by your plan; we may bill you directly for those charges. If current insurance coverage cannot be verified prior to each appointment, payment will be due at the time of service.

Providing the highest quality of medical care for our patient is our primary concern. We are more than willing to provide that care within your insurance plan guidelines, whenever possible. With your cooperation you should be able to receive all the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care.

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care.

Please initial below that you have read and understand the financial policy of our office.

_______ (Initial) We are pleased to assist you by billing for our contracted Insurers. However, the patients is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.

_______ (Initial) Patients are responsible for the payments of co-pays, coinsurances, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office.

_______ (Initial) I understand that my insurance contract is between my insurance company and me. It is the responsibility of the patient to know and understand their medical insurance benefits. If my insurance has not paid my claim within 60 days for the date insurance was billed, I will be responsible for payments. I also agree that I am responsible for any charges that my insurance company will not cover. I understand that failure to pay my account or make suitable financial arrangements may result in my account being placed in a state of delinquency. If this becomes necessary, I agree to pay all collection fees, which include but are not limited to collection fees, court fees, attorney fees, and any other fees for the collection of my account balance. If your account is sent to collections, there is a possibility that you may be discharged from the practice.

_______ (Initial) Please give our office staff at least **24 hours**' notice of cancellation of your appointment. If not, there will be a $25.00 charge for same day cancellations or no-show appointments and a $50 charge for cancelled or no show appointment if it is a test or procedure.

_______ (Initial) I also understand that if I write a check that is returned for any reason, I will be charged a fee.

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance company; and thereby authorized payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by me.

____

Printed Name of Patient or Responsible Party

X____ _______________________

Signature of Patient or Responsible Party **Date**

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

MESSAGES

May we leave a message on your answering machine at home or on your cell phone? YES / NO

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

Spouse: ____

Children: ____

Children: ____

Children: ____

Other: ____

This consent was signed by:

Patient's Name (Please Print): ____________________________________ DOB: _______________________________

Signature: ____ Date: _______________________________

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Medical Records Release Form

____

Legal Last Name Legal First Name Legal Middle Name Birth Date

____

Address Apt # City State Zip

I hereby Authorize and request you to release my medical records to:
Sun Kim. MD
5832 Beach Blvd Suite#206
Buena Park CA 90621

X_________________________________ ______________________
Authorized Signature **Date**

OFFICE USE ONLY:

Please release my complete medical history that is in your possession concerning my diagnosis and/or treatment during the period from:

______/______/______ to ______/______/______

To: (Name of Facility) _____________________________

____

Address Apt # City State