Richard Kim, M.D.

Hand & Wrist Surgery, Congenital Hand Surgery, Plastic & Reconstructive Surgery

Date: _____

Full Name: _____. **Birthdate:** _____ / _____ / _____

Gender Identity: _____

Address: _____ **Suite/Apt #**: _____

City: _____ **State**: _____ **Zip Code**: _____

E-mail: _____

Cell #: _____ **Home #**: _____ **Work #**: _____

Emergency Contact Name/Number: _____

Primary Care Physician: _____

Referring Physician (if different from PCP):_____

Pharmacy Name/Telephone: _____

Insurance Subscriber Name: _____ **D.O.B:** _____

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Reason for your Visit:

Briefly describe your present symptoms:

How did you hear about our clinic:

If this is an injury/ Worker's Comp case, please describe your injury:

Date of Injury: _____ **Name of Insurance**: _____

Rep Name/Number: _____ **Claim #**: _____

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Height: _____

Weight: _____

Past Medical History:

☐ High blood pressure	☐ Asthma	☐ COPD
☐ Diabetes	☐ Stroke	☐ Lung disease:_____
☐ Hypothyroidism	☐ Kidney disease: _____	☐ Hepatitis
☐ Heart problems:_____	☐ Bleeding disorder: _____	☐ Liver disease:_____
☐ Rheumatoid arthritis	☐ Stomach ulcers	☐ HIV/AIDS
☐ Cancer: _____	☐ Gout	☐ Current infection: _____

Other Medical Conditions (please list) :

_____

_____

_____

_____

Surgical History (please list) :

_____

_____

_____

_____

Allergies:

_____

_____

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Social History:

☐ Smoking: _____pack/day Start date: _____ Quit date: _____

Recreational Drug Use (circle one): Yes No

Alcohol Consumption (circle one): Daily Socially Never

Medications:

_____ Dosage _____

_____ Dosage _____

_____ Dosage _____

_____ Dosage _____

_____ Dosage _____

Family History:

Mother: _____

Father: _____

Siblings: _____

Children: _____

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HIPAA Information and Consent

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguard to protect your privacy.

A Notice of Privacy Practices should be available to you in the office. The notice provides information about how we may use and disclose protected health information about you in order to carry out treatment, payment, and healthcare operations, and for other purposes permitted or required by law. the notice also contains information about your rights under the law

Additional information is available from the U.S. Department of Health and Human Services.

By signing below you understand and agree to the terms of our notice of privacy practices which include:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Authorization is required for certain disclosures of your Protected Health Information.
- You have the right to opt out of fundraising communications.
- You have the right to restrict disclosures of your Protected Health Information under certain circumstances.
- You have the right to be notifies of a breach of unsecured Protected Health Information.

By signing below you understand and agree that:

- The practice has a Notice of Privacy Practices that you have had the opportunity to review.
- The practice reserves the right to change the Notice of Privacy Practices and if we change our notice you may obtain a revised copy by contacting our office.
- You may revoke this consent in writing at any time ad all future disclosures will cease.
- The practice may condition treatment upon the execution of this consent.

I also give permission to Dr. Richard Kim to receive any medical information pertaining to my treatment from another doctor’s office, imaging facility, and/or hospital.

_____ _____

Print Name Signature and Date

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Insurance Acknowledgement

This is to inform you that Dr. Richard Kim is **OUT-OF-NETWORK** with all insurances **except**:

Medicare (Traditional and Non-Combination Plans)

Most BCBS Plans (**excluding** NJ Health, Empire, Anthem, Braven Medicare Plus HMO, Medicare Blue Advantage HMO, Medicare Clue Select HMO-POS)

If this is your primary and you have a secondary, our billing company will submit the remaining balance to the secondary.

If you are using your **OUT-OF-NETWORK** benefits, we will submit a claim to your insurance first.

Self-Pay Information

If you are a Self-Pay patient, the consultation fee (1st time) is $300 and the follow-up fee is $100 per visit. If there is any other treatment besides a physical examination and questioning, there will be additional fees added to the office visit fee.

Dr. Kim or the staff will let you know what the additional fees are and payment is due at the end of your visit.

If surgery is needed, the payment is discussed case by case.

Please sign and date below to acknowledge you have read the statements above.

_____

Signature and Date

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ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE/LIMITED SPECIAL POWER OF ATTORNEY

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign and print your name below and enter today's date.

Assignment of Benefits

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any penalties or equitable relief) under my health insurance policy or benefit plan to Richard Kim, M.D. LLC and Fellows Health Partners (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service, including without limitation, the right of one or more of the Providers, or their attorney (or other representative) to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State laws, rules, regulations or requirements (collectively, "Laws"), (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator (or other fiduciary) to timely produce or respond to requests (including appeals) for all information relating to any plan documents as required by any applicable Laws, (iii) to assert claims and initiate legal action for breach of fiduciary duty against and person or entity, and (iv) to endorse for me any checks made payable to me for benefits and claims collected toward my account.

In the event the insurance carrier responsible for making medical payments to Richard Kim, M.D. LLC and Fellows Health Partners for medical services rendered to me does not accept my assignment of benefit rights, or my assignment is challenged or deemed invalid, I execute this limited/ special power of attorney and appoint and authorize Provider and his/her/its attorney (or other representative) as my agent and attorney, in fact, to assert any and all of my benefit and non-benefit rights for and on my behalf, including, without limitation, to bring any appeal, pre-litigation demand, demand for payment, arbitration, lawsuit, independent dispute resolution or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination and payment of benefits under any insurance policy or benefit plan. I agree that any recovery shall be applied to payment due my provider and attorney fees and costs. To this end, Provider has exclusive settlement authority.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers (including the Law Offices of Cohen and Howard) or any other person or business that provides healthcare activity services as a "business associate' under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

1. The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.
2. The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and protected health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPAA.
3. The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.
4. The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.
5. The right of my Authorized Representative to pursue any rights, claim or cause of action through pre-litigation demands, demands for payment, arbitration, independent dispute resolution or administrative proceeding, litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

Release of Private Health Information

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or thirdparty payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization/ Limited Special Power of Attorney shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name: _____ Date:_____

Patient Signature: _____

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No Show/Cancellation Policy

We schedule our appointment so that each patient receives the right amount of time to be seen by Dr. Richard Kim. That is why it is very important that you keep your scheduled appointment with us, and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, Richard Kim M.D. LLC sends out automated voice calls reminding you of your appointment 4 days and 1 day prior to your appointment time.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule their appointments, please give us at least 24 hours notice.

If you do not cancel or reschedule your appointment with at least 24 hours, we may assess a $25 “no show” service charge to your account. This “no-show charge is not reimbursable by your insurance company. You will be billed directly for it.

After three consecutive no shows to your appointment, our practice may decide to terminate its relationship with you.

Please Initial and Sign Below

____ I understand the “no show” policy of Richard Kim M.D. LLC and agree to the terms outlined above.

____ I understand that I must cancel or reschedule any appointment at least 24 hours in advanced to avoid a potential no-show charge to the credit card provided.

_____ _____

Patient Name **Date**

_____ _____

Patient/Guarantor Signature **Relationship to Patient**