Min H. Kim MD

Board Certified in Internal Medicine

NEW PATIENT REGISTRATION FORM

Today's Date (오늘 날짜) _____ / _____ / _____	**Insurance Information** (보험) Do You have Insurance? ❑ Yes ❑ No If yes, NAME of Insurance Company:		
Patient's Name (환자성함)	**Birth Date** (생년월일)	**Gender** (성별)	**SSN** (소셜넘버)
Last Name: First Name:	— —/ ——/————	❑ **M** (남) ❑ **F** (여)	— —

ADDRESS (주소)	**Marital Status**	**Number of Children**
_____ _____ City State Zip Code	□ **Married** (결혼) □ **Single** (미혼) □ **Widowed** (미망인) □ **Divorced** (이혼)	(자녀 수)
E-mail : (이메일)		

Phone Number (전화번호)	**Emergency Contact** (비상연락처)	**Occupation** (직업)
Please write your primary contact number. **Home :** (집) **Cell phone :** (휴대폰)	*In case of emergency, who to notify. **Phone Number :** (전화번호) **Name :** (성함) **Relationship :** (관계)	**Employer's Name:** **Contact Information:** (If available)

Racial Category

□ American Indian or Alaska Native □ Asian □ White □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ Other Race □ Decline to Specify

Are you Hispanic or Latino? (히스패닉이나 라티노 이십니까?) □ **Yes** (예) / □ **No** (아니오)
Preferred Language (어떤 언어를 사용하십니까?) _____
Do you need a translator? (통역사가 필요하십니까?) □ **Yes** (예) / □ **No** (아니오)

Name of Pharmacy (약국이름)	
Address of Pharmacy (약국주소)	

Initial Patient History / Questionnaire

***Do you have or ever had any diseases or conditions? Please list all of them. Ex) Diabetes, Hypertension, etc..**

질병을 앓으신 적이 있으십니까? 있으시다면 어떤 것이 있습니까? 예) 당뇨, 고혈압 등등

□ Yes / □ No

Name of Disease (종류)	**Since when? (날짜)**

***Please list all your current medications with dosage and vitamins.**

현재 복용하시는 약과 비타민제를 용량과 함께 작성해 주세요.

□ Yes / □ No

Name of Medication (약/ 비타민 이름)	**Dosage (용량)**

***Please list any surgery and hospitalization w/ approximate date.**

수술 및 입원 기록과 날짜를 모두 작성해 주세요.

□ Yes / □ No

Name of Surgery (수술 종류)	**Date (날짜)**

***Please list any allergies and list the reaction.**

약 알러지 반응 혹은 평상시에 알레르기가 있으시다면 작성해 주세요.

□ Yes / □ No

Name of Agent/Substance (약 종류)	**Reaction of allergy** (알러지 반응)

***Please list the Family Disease History.**

직계가족 중 질병이 있으신 분이 계십니까? 있으시다면 작성해 주세요.

□ **Yes** / □ **No**

Father (부) _____

Mother (모) _____

Siblings (형제 자매) _____

Other Relatives (친척) _____

*** What is your main reason for coming to the doctor today?**

오늘 저희 병원을 방문하신 목적을 말씀해주세요.

_____

_____

***Are you currently sexually active?** (현재 성생활을 하시나요?) : □ **Yes** / □ **No**

***Do you smoke?** (담배를 피우십니까?) □ **Yes** / □ **No**

If YES, how many per day? (만약 피우신다면 하루에 어느 정도 피우십니까?)_____

***Do you drink coffee?** (커피를 드십니까?) □ **Yes** / □ **No**

If YES, how much per day? (만약 드신다면 하루에 몇 잔 드십니까?)_____

***Do you drink alcohol?** (술을 드십니까?) □ **Yes** / □ **No**

If YES, please list the type and how much you drink per day.

(만약 드신다면 종류와 주량을 기입해 주시기 바랍니다.)

_____

***Are you employed?** (일을 하십니까?) □ **Yes** / □ **No** / □ **Retired** / □ **Self-Employed**

If YES, what is your job? (어떤 일을 하고 계십니까?)

_____

Last colonoscopy date (대장 내시경 날짜): _____ **Result** (결과) **:** _____

Previous primary care physician. Have you seen by any doctor such as family medicine or internal medicine?
(다른 내과 또는 가정의학과를 다니신 적 있습니까?)

If YES, what is the name of facility? (병원 이름 작성해주세요)

_____

** FEMALE ONLY
Last pap smear date (자궁 경부 암 검사 날짜): _____ **Result (**결과) **:** _____
Last mammogram date (유방암 검사 날짜): _____ **Result** (결과)**:**_____

Referral Source. Please check all that apply. (어떻게 혹은 누구의 소개로 오셨습니까? 해당항목을 체크해주세요.)

Another client (지인소개)		**Primary Care Physician** (주치의)		**Advertisement** (광고)	
Search Engine (인터넷)		**ZocDoc/ Patient pop** (웹사이트)		**Other:**	
Newspaper (신문)		**Social Network** (소셜 네트워크)			

Any Other Comments:

ASSIGNMENT OF BENEFITS

Please select the option(s) according to your insurance provider

- **ALL INSURANCE**

  I authorize my insurance provider to pay benefits directly to John Lee OB/GYN and Min H Kim Internal Medicine on my behalf. I allow John Lee OB/GYN and Min H Kim Internal Medicine to provide my insurance company with any required information for the processing of claims related to services rendered to me.

  _____ _____

  Signature as it appears in your insurance card Date

- **MEDICARE**

  I authorize any holder or medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carry any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts the payment. Regulations pertaining to Medicare assignment of benefits apply.

  _____ _____

  Signature as it appears in your Medicare card Date

- **SUPPLEMENTAL/MEDIGAP/SECONDARY**

  If you have a supplemental/MEDIGAP policy to which your Medicare Carrier automatically “crosses over”, we are required to keep a separate signature on file:

  I request authorized Supplemental/MEDIGAP benefits be made on my behalf for any services rendered to me. I authorize any holder of medical information to release to my Supplemental/MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

  _____ _____

  Signature as it appears in your MEDIGAP Card Date

- **MEDICAID**

  The Medicaid insurance plan has restrictions, which patients may have to pay self if the patient has limited coverage and the patient fails to tell us prior to the visit.

  _____ _____

  Signature Date

FINANCIAL POLICY - Page 1 of 2

Our goal is to provide excellent care and superior patient service. Our policies are printed below. Your agreement to follow these policies will help us serve you.

Payment

- Our office accepts cash, debit cards, Visa, MasterCard, American Express, and Discover Card
- If your insurance cannot be verified at the time of your visit, you may reschedule or be a Self-Pay patient
- Insured patients: Co-payments and any account balances (from previous visits) are due at the time of service.
- Self-Pay Patients: For patients without insurance, an office visit fee ($130 for New, $70 Established patient) via credit card or cash is due at time of check-in. Any difference in visit cost will be settled at time of check-out. A self-pay quote for services is available upon request.

Insurance:

- We will file claims to your insurance carrier and accept payment directly from them. It is the patient's responsibility to keep us informed with up to date insurance coverage and contact information. Visits will be filed with the insurance information on file. We are not responsible for insurance claims returned due to a change in carriers. Patients are fully responsible for all costs denied by their insurance or if incorrect information was provided at time of check-in.
- It is your responsibility to know your insurance benefits. We can never guarantee insurance coverage for any service provided. THE PROCEDURES NOT COVERED BY INSURANCE IS PATIENT'S RESPONSIBILITY.
- If your insurance plan requires a referral or prior authorization, it is your responsibility to obtain this prior to your visit.
- MEDICARE PATIENTS: If you are currently covered under Medicare, please present ALL insurance cards at the time of your visit. Medicare offers a Medicare Advantage plan in lieu of traditional Medicare. If you have chosen an Advantage plan and do not present the correct card, you will be responsible for any denied charges.
- Insurance Claims: It is patient responsibility to verify benefits including in network vs out of network status with our office and providers. We do not guarantee coverage for any visits or procedures responsible for all services performed at John Lee OB/GYN and Min H Kim Internal Medicine. Patients are ultimately responsible for all services should insurance deny a claim for ANY reason.

By signing this form, I am stating that I have read the information above on page 1 and 2 and understand my financial responsibility for my account.

_____	_____	_____
Patient/Guardian Name	Signature	Date

Insurance Continued:

- Out of Network Insurance: WE DO NOT FILE with insurance carriers with how we do not hold a contract. All out of network patients will be self-pay patients. Self pay charges are due at time of service. If we become informed from an insurance carrier that a filed claim is actually out of network, the claim may be pulled from the carrier, the bill may be reverted to self-pay rates and the balance will be owed by the patient.

Labs

- Labs ordered through our office are billed separately to your insurance from the laboratory and are NOT billed to insurance by John Lee OB/GYN and Min H Kim Internal Medicine.The patient understands that all charges not covered by insurance is the patient's responsibility.
- The patient will direct any questions regarding a bill or statement from the outside lab to the lab directly.
- If your insurance requires that tests be sent to a specific lab, it is your responsibility to tell the medical assistant, at the time the test is ordered.

Collections

- Balances are due within 30 days of the first statement date.
- Past due balances: In an effort to protect patients' credit rating and to be reimbursed for services rendered, any account with an outstanding balance past 90 days will be charged in full to the credit card presented for charges on any date of service whose balance is outstanding.
- All credit card information is automatically stored on the cloud via our credit card processing company WAYSTAR(Zirmed). I understand that my signature and payment information will be maintained on file digitally for future use by the practice. The applicable payment card or ACH information will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information. Card or ACH Information will be obtained through a card swipe, manual entry from card, void check, or orally in person or over the phone.

Misc

- All patients who "no show" to an appointment or who cancel less than 1 John Lee OB/GYN and Min H Kim Internal Medicine business day (Federal Holidays not included) in advance will have a $25 no show fee added to their account. Repeated no shows will result in the dismissal from the practice.
- Returned checks: patients are responsible for the full amount of any returned check plus a $35 returned check fee.

By signing this form, I am stating that I have read the information above on page 1 and 2 and understand my financial responsibility for my account.

Patient/Guardian Name	Signature	Date

Patient Acknowledgement & Designation Disclosure

I acknowledge that I have read/ or have been provided a copy of the Notice of Privacy Practice, and I understand the Notice of Privacy Practices and agree to its terms.

I acknowledge that as part of the healthcare services provided by John Lee OBGYN and Min H Kim Internal Medicine, health records containing my health information are generated and maintained. This includes but is not limited to my health health history, symptoms, diagnoses, examination and test results, treatment, and any plans for future treatment, personal information, and insurance data.

By signing this form, I agree that John Lee Obstetrics and Gynecology and Min H Kim Internal Medicine may disclose my health information for the purpose of treatment, payment and health care operations. I acknowledge that this consent remains valid unless I revoke it in writing and submit it to John Lee OBGYN and Min H Kim Internal Medicine.

_____
Patient's Printed Name

_____ _____
Signature Date

I authorize and give permission to John Lee OBGYN and Min H Kim Internal Medicine, to disclose and discuss any information related to my medical condition(s) to/with the following persons:

_____ _____
Name Relationship

_____ _____
Name Relationship