RICHARD KIM MEDICINE

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## PATIENT INFORMATION

Today's Date_____

Last Name:_____First Name_____ Middle___
Mailing Address_____
City:_____State:_____ Zip Code_____
Date of Birth_____ Home Phone:_____Work Phone_____Cell Phone_____
Email Address:_____ Sex: Male__ Female__ Marital Status _____

**REFERRAL INFORMATION**: (Please check the appropriate box below to help us determine how you were referred to our office)
__Physician __Friend __Relatives __One of our patients __Internet __Insurance __-Facebook
Primary or Referring Physician:_____

Person to contact in case of emergency:_____Phone:_____
To better serve our patients, we will automatically fax all prescriptions to the pharmacy for you:
Pharmacy:_____Phone:_____Fax_____
Pharmacy Location_____

INSURANCE COVERAGE-(Please present insurance card(s) and photo ID to receptionist)
Primary Card HolderName:_____ Relationship to patient_____DOB:_____

## AUTHORIZATION AND FINANCIAL POLICY

I, the undersigned certify that I (or my dependent) assign directly to Richard Kim, M.D., all insurance benefits for services rendered. Medicare and/or other insurance carriers will only pay for services that it determines to be "reasonable and necessary." If my insurance company determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under my policy with my insurance carrier, they may deny payment for these services and I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

My signature below shows that I understand that all copayments, coinsurance, deductibles, non-par insurance and self pay are due at the time services are rendered. I understand that Richard Kim, M.D. has the right to charge me $35 for any returned check.

**CANCELLATION FEE POLICY**-My signature below shows that I understand the cancellation policy: $50 Fee for less than 24 hours notice of cancelation for consult or follow up office visits or not showing for the appointment. $200 Fee for less than 7 days notice for scheduled procedures or not showing for the appointment. I also understand that payment of these fees must be made prior to any future appointments being scheduled. Please note: all Stem Cell and PRP deposits are non-refundable.

**For HIPAA Compliance, please answer the following questions**:
I authorize you to leave appointment messages or send information to me via:
____Answering Machine ____With another person ____Mail ____Email

My signature below also indicates that I have been provided Richard Kim Medicine Notice of Privacy Practices.

My signature below authorizes Richard Kim, M.D. general consent for evaluation, treatment and the understanding of Richard Kim Medicine Financial and Cancellation Policy.

Signed:_____ Date:_____
Patient or person authorized to consent signature
If Guardian, state relation:_____

We gladly accept Cash, Checks, MC, VISA, AMEX, DISCOVER. We also offer CARE CREDIT.