RICHARD KIM MEDICINE

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Gansevoort, NY 12831
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richardkimmedicine.com

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 __Google __Insurance __Facebook__WNYT13 __Spectrum TV-Albany __Spectrum TV-Rochester/Syracuse __NBC 3 Central NY __CBS5 Central NY __Fox 23 __ABC10 __Jeopardy Syracuse/Rochester __Jeopardy Capital District __Postcard __Post Standard __Times Union __Primary or Referring Physician:_____ __Other_____

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_____

AUTHORIZATION AND FINANCIAL POLICY

I, the undersigned certify that I (or my dependent) understand that Richard Kim Medicine, is a Direct Pay Practice and agree to sign the Opt Out Contract and accept full financial responsibility for services performed by Richard Kim, M.D.

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: $95 Fee for less than 24 hours notice of cancellation for consult and 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.

I, the undersigned, certify that I (or my dependent) understand that **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.