KIM MEDICAL GROUP

Chart #_____

A. PATIENT INFORMATION

SOCIAL SECURITY # _____

FIRST NAME _____ MIDDLE_____

LAST NAME_____

SEX_____ DATE OF BIRTH _____/_____/_____

MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED ☐ MINOR

OF CHILDREN: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ Other_____

RACE _____

PREFERRED LANGUAGE _____

HOW DID YOU HEAR OF US? _____

HOME ADDRESS_____

CITY_____ STATE_____ ZIP _____

EMAIL_____

HOME PHONE (_____) _____

CELL PHONE (_____) _____

EMPLOYER NAME _____

WORK PHONE (_____) _____

WORK ADDRESS_____

CITY_____ STATE_____ ZIP _____

I GIVE PERMISSION TO LEAVE MESSAGES REGARDING MY HEALTH INFORMATION AT: ☐ HOME ☐ CELL ☐ BOTH

B. INSURANCE INFORMATION

Do you have insurance? ☐ Yes ☐ No **** PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST ****

C. EMERGENCY CONTACT

FIRST NAME _____ MIDDLE_____

LAST NAME_____

SEX _____ RELATIONSHIP TO PATIENT _____

HOME PHONE (_____) _____

CELL PHONE (_____) _____

Do you have an Advance Healthcare Directive?_____

Would you like information?_____

D. ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ **and assign directly**
Name of Insurance Company(ies)
to Kim Medical Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year form the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date Relationship to Patient

Kim Medical Group

PEDIATRIC MEDICAL HISTORY

Date:____/____/____

Patient Name_____ Dob____/____/_____ Chart# _____

PREGNANCY (Mother's History)

Gravida_____ Para_____ Ab____ Living____
Children_____
Maternal Age ____
Prenatal Care: Yes____No____Site_____
Problem: Yes____No____
If yes, Indicate below;

___Swelling of Extremities
___Convulsions
___Anemia
___Rubella
___STD
___X-ray during pregnancy
___High BP
___Bleeding, Vaginal
___Diabetes
___PPD positive
___Surgery
___Other

During pregnancy, any of the following?
___Smoking ___Alcohol use ___Prescription Meds
___Over the counter Meds ___Drug use

BIRTH

Date of Birth:_____/____/____
EDC: _____
Site of Delivery: _____
Gestation (wks): _____
Type of Delivery: ____C/Section ____NSVD
Birth Weight: _____
Birth Length: _____
Nursery Problem: _____
Comments:

NEONATAL PROBLEMS

Any problems in first month? Yes____ No____
If yes, indicate below;

____Congenital Anomalies
____Jaundice
____Feeding
____Re-hospitalization
____Breathing problem
____Anemia
____Infection
____Other

CHILDHOOD PROBLEM

Has this child had any of following problem?

____Drug Allergy
____Other Allergy
____Asthma
____Anemia/Blood Disease
____Convulsions
____Developmental problem
____Ear/Nose/Throat
____Endocrine
____Eye
____Gastrointestinal
____Genitourinary
____Heart
____Musculoskeletal
____Nervous System
____Psychological
____Respiratory
____Skin
____Tuberculosis
____Hospitalization
____Operation
____Serious Injury
____Poisoning
____Other

FAMILY HISTORY

Present age of Mother _____, Father_____,
Number of Siblings _____
Family history of any serious illness/disease?

____Alcohol/Drugs
____Asthma
____Birth Defects
____Blood Diseases
____Cancer
____Diabetes
____Developmental prob.
____Epilepsy
____Heart Disease
____HIV/AIDS
____Obesity
____Hypertension
____Mental Illness
____Tuberculosis
____Other (specify)

SOCIAL HISTORY

Child lives with
____Both parents _____Mother _____Father
____Relatives ____Other (specify)

KIM MEDICAL GROUP MRN:_____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45CFR Parts 160 and 164)

1. I hereby authorize Kim Medical Group to use and/or disclose the protected health information described below to

_____
[Name of Person(s) and Relationship]

_____
[Name of Person(s) and Relationship]

_____
[Name of Person(s) and Relationship]

2. Authorization for Release of Information. Covering the period of health care from
☐ _____ to _____ **OR** ☐ all past, present and future periods:

a. ☐ I hereby authorize the release of my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, treatment of alcohol/drug abuse and financial).

OR

b. ☐ I hereby authorize the release of my complete health record with the exception of the following information:
   - ☐ Mental health records
   - ☐ Communicable diseases (including HIV and AIDS)
   - ☐ Alcohol/drug abuse treatment
   - ☐ Other (please specify): _____

3. This authorization shall be in force and effect until _____, at which time this authorization expires.
[Date]
4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.
7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Relationship to Patient

Kim Medical Group

2500 Alton Parkway, Suite 108, Irvine, CA 92606

(949) 552-8282

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Bangsun Justin Kim, M.D. Internal Medicine KMG KIM MEDICAL

To our patients:

Thank you for visiting Kim Medical Group.

We would like to notify you of a situation that could arise when you have blood drawn or biopsies done in our clinic.

We take blood samples and perform biopsies in our clinic; however, we send the samples to the laboratory, and the lab runs the actual tests. Our office sends the claim to the insurance company for the procedure, but it is the lab that sends the claim to the insurance company for the testing of the samples.

Other than what the insurance company has paid to the lab, it is the patient's responsibility to pay the remaining portion if it applies to the patient's deductible or coinsurance. This bill must be paid directly to the lab.

Kim Medical Group is not responsible for any bills that are sent to the patient from the laboratory. Any questions regarding laboratory bills should be directed to the laboratory. Please be advised that any payments that are not rendered to the laboratory could be detrimental to your credit.

If you have any questions regarding the above content, please ask us before any tests are performed.

Thank you.

I acknowledge the above content.

Patient Name: _____

Patient Signature: _____

Date: _____

KIM MEDICAL GROUP
Medication Refill Policy

We receive many phone calls each day in regards to medication refill requests, which take valuable staff and physician time to address. Thus, we have changed our medication refill policy. We understand that this is a change for both you and us, and ask for your understanding. Your cooperation with this policy will allow us to provide you with quality clinical care.

Please plan ahead!

1. At the time of your appointment, you will be provided with a sufficient amount of routine medication until your next scheduled appointment. It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations will result in denial of refills.
2. If you think you will run out of your medication prior to your scheduled appointment, please **contact your pharmacy** at least **THREE** days before your medication is due to run out. If you use a mail-order pharmacy, please contact them at least **FOURTEEN** days before your medication is due to run out. Your pharmacy will then contact us by fax, phone, or electronic request to inform us that you are in need of a refill.
3. Any medications that are not taken on a daily basis (i.e. antibiotics) usually require an office visit for evaluation.

If you have any questions or concerns, please ask the receptionists at the front desk. Thank you.

Patient Name: _____

Patient Signature: _____ **Date**: ___/___/_____