PATIENT INFORMATION

DATE _____/_____/_____

FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

DATE OF BIRTH _____/_____/_____ SOCIAL SECURITY NUMBER _____-_____-_____ GENDER __ MALE __ FEMALE

MARITAL STATUS __ MARRIED __ SINGLE __ DIVORCED __ SEPARATED __ WIDOWED

ADDRESS _____ APARTMENT/SUITE_____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

RACE _____ ETHNICITY _____ PRIMARY LANGUAGE _____

EMPLOYMENT STATUS __ EMPLOYED __ SELF EMPLOYED __ UNEMPLOYED __ DISABLED __ RETIRED __ STUDENT

OCCUPATION _____ EMPLOYER _____

EMERGENCY CONTACT _____ RELATION _____ PHONE _____

PHARMACY INFORMATION

PHARMACY NAME _____ PHARMACY PHONE NUMBER _____

PHARMACY ADDRESS (CROSS STREETS) _____

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY _____ PHONE _____

ID/SUBSCRIBER NUMBER _____ GROUP NUMBER _____

SUBSCRIBER NAME _____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER SSN _____-_____-_____ SUBSCRIBER DOB _____/_____/_____ SUBSCRIBER GENDER __ M __ F

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

NAME OF INSURANCE COMPANY _____ PHONE _____

ID/SUBSCRIBER NUMBER _____ GROUP NUMBER _____

SUBSCRIBER NAME _____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER SSN _____-_____-_____ SUBSCRIBER DOB _____/_____/_____ SUBSCRIBER GENDER __ M __ F

MEDICAL HISTORY

Patient Name: _____ Today's Date: _____

DOB: _____ Height: _____ Weight: _____

What are you seeing the doctor for today: _____

Daily Medications: (please include pain medications, herbs, vitamins & over the counter medications)

Name	Dosage/Strength	Times/day	Name	Dosage/Strength	Times/day

Past Surgical History: (list type and date)

_____

_____

_____

Past Hospitalizations: (list reason and date)

_____

_____

_____

Have you received any of the following vaccines?

Influenza	▢Yes	▢No	Date Received: _____
Pneumonia	▢Yes	▢No	Date Received: _____
Tetanus	▢Yes	▢No	Date Received: _____
Shingles	▢Yes	▢No	Date Received: _____

Have you had a:

Colonoscopy: ▢Yes ▢No (if yes, please list most recent date) _____

Pap smear: ▢Yes ▢No (if yes, please list most recent date) _____

Mammogram: ▢Yes ▢No (if yes, please list most recent date) _____

Dexa scan: ▢Yes ▢No (if yes, please list most recent date) _____

Drug Allergies: ▢Yes ▢No (if yes, please list drug and reaction)

_____ _____ _____

_____ _____ _____

Past Medical History: (check conditions)

- ▢ Anemia
- ▢ Diabetes
- ▢ Cancer/Type _____
- ▢Kidney Trouble
- ▢ Bladder Issues
- ▢ High Blood Pressure
- ▢ Heart Trouble
- ▢ High Cholesterol
- ▢ Asthma
- ▢ Neurological Disorder/Seizures
- ▢ Depression
- ▢ Stroke
- ▢ Thyroid Disorder
- ▢ Ulcer/Stomach Problems
- ▢ Sleep Apnea
- ▢ Hepatitis
- ▢ Arthritis
- ▢ Gout
- ▢ Phlebitis/Blood Clots
- ▢ AIDS/HIV
- ▢ Substance Abuse
- ▢ Fibromyalgia

Please list any major medical conditions of your **immediate Family Members**:

Father: _____ Alive Deceased (circle one)

Mother: _____ Alive Deceased (circle one)

Sibling: _____ Alive Deceased (circle one)

Sibling: _____ Alive Deceased (circle one)

Do you **use tobacco**? ▢Yes ▢No

How often? _____

For how many years? _____

Do you **exercise**? ▢Yes ▢No

How Often? _____

What type? _____

Do you drink **alcohol**? ▢Yes ▢No

If yes, average consumption per week? _____

Is there any possibility you could be **pregnant**? ▢Yes ▢No

Do you have an **advance directive**? ▢Yes ▢No

Kavya Medical

OFFICE AND FINANCIAL POLICIES

Welcome to Kavya Medical. We are committed to giving you the best care possible and would like to take this opportunity to inform you of our office financial policies.

New Patients: All new patients must **complete the new patient paperwork** before seeing the provider. Information must be updated when changes occur. It is your responsibility to let us know of changes in address, phone number, email, insurance, pharmacy, etc.

Insurance Billing: We are only responsible for filing claims to contracted insurance companies. We file claims as a courtesy to our patients. Any deductibles, co-insurance and non-covered services are your responsibility.

Deductibles and Co-pays: Full payment is due at the time services are rendered. This includes co-payments, deductibles, and services not covered by your insurance. If you are on a high deductible plan we collect $150 for new patients and $100 for established patients until the deductible has been met. If you are not able to pay your co-pay or deductible you may be asked to reschedule your appointment.

Returned checks: There will be a $25 fee assessment for returned checks for non-sufficient funds, stop payments, and account closures. Your account will be flagged for failure to pay and checks will no longer be accepted as a form of payment for your account.

Appointment cancellation and no shows: We will attempt to contact you for appointment reminders; however, it is the responsibility of the patient to arrive for his/her appointment on time.
We ask that you notify us 24 hours in advance to cancel and /or reschedule your appointment**.**

Prescription refills: We only provide prescription refills during an office visit with a provider. We require office visits on a regular basis for all patients taking prescription medications. Please bring all prescription bottles and a current detailed medication list with you to your appointment. As of October 2017, we will no longer respond to refill requests from pharmacies.

Referrals: All referrals will require an evaluation in the office. If your insurance requires an authorization please keep in mind that it will take from 5-7 business days for referral to be completed.

Disability and FMLA paperwork: FMLA forms require that you come in for an appointment. Please allow 10 to 14 days for the completion of these forms. If you would like the forms mailed or faxed to you or the insurance, payment will be due prior to mailing or faxing.

Outstanding balances/collections: Prior to providing additional services to you, payment in full of total outstanding balances will be required. If you have an outstanding balance for 6 months your account will be sent to an outside collection agency and you will be dismissed from our practice.

Dismissal: If you are “dismissed” from the practice it means you can no longer schedule appointments, get medication refills or consider us to be your doctor. You have to find a doctor in another practice.

Common Reasons for Dismissal:

- Failure to keep appointments, frequent no-shows
- Non-compliance, which means you won't follow physician instructions about an important health issue
- Abusive to staff
- Failure to pay your bill

Dismissal Process: We will send a letter to your last known address, via certified mail, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on this letter, we will see you. After that, you must find another doctor. We will forward a copy of your medical record to your new doctor after you let us know who it is and sign a release form.

Acknowledgement: I acknowledge that I have received and read a copy of the Office and Financial Policies.

_____

Patient/Guarantor Name (please print)

_____

Signature of Patient/Guarantor Date: _____

Thank you for understanding our office policies. We are excited you chose Kavya Medical as your primary care facility!

PATIENT PORTAL POLICY

Purpose of this Form:

Kavya Medical offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool but has certain risks. In order to manage these risks, we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works:

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass- phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Protecting Your Private Health Information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect, and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:

1) the secure message must reach the correct email address, and

2) only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. **It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address.** You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Types of Online Communication/Messaging:

Online communications should never be used for emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact your physician via telephone. If there is information that you don't want transmitted via online communication, please inform your practice.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

_____ **DATE:** _____/_____/_____

PATIENT SIGNATURE

_____**PATIENT NAME (PRINTED)**

PATIENT SIGNATURES

Acknowledgement of Notice of Privacy Practices:

I have been offered a copy of the Notice of Privacy Practices. I understand that Kavya Medical has the right to change its Notice of Privacy Practices from time to time and that I may contact Kavya Medical at any time to obtain a current copy.

****Signature:** _____ Date: _____

Authorization for Release of Health Information:

I hereby authorize Kavya Medical to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved with my care. I also authorize the release of information that may be necessary in the processing of any insurance claims.

I hereby authorize Kavya Medical and its Employees permission to discuss, send and/or receive my personal health information to/with the following individual(s):

Name: Relationship: Phone:

Name: Relationship: Phone:

****Signature:** _____Date: _____

Authorization for Release of Prescription Information:

I hereby authorize Kavya Medical to release any prescription information to:

Name of Pharmacy _____ Cross Streets: _____

****Signature:** _____ Date: _____

Acceptance of Patient Financial Agreement:

I have read, understand, and agree to the provisions of the Patient Financial Responsibility Policy.

****Signature:** _____ Date: _____

Acceptance of Patient Portal Authorization:

▫ I am declining activation of my Patient Portal Account.

▫ By signing below, I acknowledge that I would like a Patient Portal account and agree to the terms and conditions set forth in the Patient Portal Authorization Policy.

Email Address: _____

****Signature:** _____Date: _____