PATIENT REGISTRATION FORM

Janet B. Kim, M.D., Inc.
26302 La Paz Rd, #106
Mission Viejo, CA 92691
Tel: 949-328-9972
Fax: 949-328-9976

Date: _____

Patient's Name: _____ D.O.B.:_____ Age:_____ Marital Status:_____
SSN:_____ Sex:_____ Drivers Lic:_____ E-mail:_____
Address: _____ City:_____ State:_____ Zip:_____
Home Phone:_____ Work Phone:_____ Cell Phone: _____
Occupation:_____ Employer: _____
Employer Address:_____ City_____ State _____ Zip:_____
Spouse / Parent if child:_____ Drivers Lic:_____ SSN: _____
Age: _____ D.O.B.:_____ Employer: _____
Occupation: _____ Business Phone:_____
Person Responsible for bill:_____
Referred by: _____
In case of Emergency, Contact Person Name:_____ Relation:_____
Phone #:_____

I certify that the information given by me is correct. I give Janet B. Kim, M.D. permission to administer to me, any examination, treatment, and medications deemed therapeutic to my condition:

_____
Signature of Patient

OFFICE POLICIES & AGREEMENTS

NOTICE TO PATIENT/RESPONSIBLE PERSON: Please read the following policies and agreements carefully. Please initial every section and then sign and date the bottom where indicated.

ELIGIBILITY/CONSENT: A signature requests for payment to be made to Janet B. Kim, M.D., Inc. and authorizes the release of any information necessary to process any claims.

_____
Signature of Responsible Party

INSURANCE SUBMISSION POLICY: The office policy is to bill your insurance company as a courtesy to our patients. However, in the event we are unable to collect from your insurance company, the responsibility of services provided to you will be the patient or responsible party. Your insurance company is required to pay within 30 days. If payment is not received within 30 days from your insurance company a bill will be sent to the responsible party for payment in full. _____ (initial)

DEDUCTIBLE/COPAYMENT POLICY: Co-payments are to be paid at the time of service. There will be no exceptions. It is the insured/responsible party's responsibility at the time of each visit to have payment available. If the deductible has not been met for the year, payment for services will be required at that time.
All insured/responsible parties should be fully aware of their benefits. _____ (initial)

I hereby certify that I have read and understood the office polices and accept total financial responsibility for all services rendered.
Patient/Guardian (sign)_____ (Print)_____ Date:_____

The signature of the patient must be obtained unless the patient is a dependent minor under the age of 18 or is otherwise incompetent to sign.

Relationship (if signed by person other than Patient) _____

Janet B. Kim, M.D., Inc.

Patient Agreement of Financial Responsibility

Your insurance will be billed as a courtesy. In the event we are unable to collect from your insurance company, **the responsibility of services provided to you will be the patient or responsible party**. It is your responsibility to understand your health insurance plan, including copays, deductibles, coinsurance, and whether you are in or out of network. Statements with patient balances are due upon receipt, and any outstanding balances must be paid in full prior to subsequent office visits.

If you have a deductible that has not been met, it is our office policy to collect a $225 deposit towards the initial consultation, $140 for follow-up visit, and $550 for any procedures such as skin testing, allergy shots, patch testing, etc. The amount you owe may end up being more. Once the claim has been processed, if you have overpaid a refund will be issued to you.

I understand that copays, deductible, coinsurance, and whether I am in or out of network are determined by my insurance are not surprise medical bills. I also understand that if my insurance does not pay, I am responsible for unpaid balances and these are also not surprise medical bills.

Returned checks will incur a fee of $40.

My signature below indicates I have read and understood the office policies, and accept total financial responsibility for all services rendered.

Patient/Guardian_____

Print_____

Date_____

Janet B. Kim, M.D., Inc.

Patient Consent for the Use and Disclosure of Protected Health Information

With your consent, Dr. Janet Kim may use and disclose protected health information (PHI) about you to carry out treatment, payment, and health care operations (HCO). Please refer to our Notice of Privacy Practices displayed in our office for a more complete description of such uses and disclosures. You have the right to revise our Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Officer at 26302 La Paz Rd Suite 106 , Mission Viejo, CA 92691.

With your consent, Dr. Janet Kim may call your home or office and leave a message in reference to any items that assist the practice in carrying out HCO such as appointment reminders, insurance items, and any call pertaining to your medical care.

With your consent, Dr. Janet Kim may mail to your home or office any items that assist the practice in carrying out HCO such as appointment reminder cards and patient statements.

I give my consent to electronically send or fax my records for the purpose of treatment, payment, or healthcare operations and understand that I may withdraw this consent at any time in writing. I understand that my medical records may be transmitted electronically or by fax and may be received in error by a third party. In the event that this should occur I absolve Dr. Janet Kim of all liability.

You have the right to request that we restrict how we use or disclose your PHI to carry out treatment, payment, and health care operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment, payment, and health care operations. This consent may be revoked in writing except to the extent that we have already made disclosures in reliance upon your prior consent. If you decline to sign this consent, we may decline to provide treatment for you.

Signature of Patient/Legal Guardian_____Date_____
(This authorization will remain standing until revoked in writing).

Print name of Patient/Guardian_____DOB_____

ONLY SIGN BELOW IF YOU ARE DECLINING THIS CONSENT

I, _____, decline to the use and disclosure of my PHI to carry out treatment, payment, and health care operations.

Janet B. Kim, M.D., Inc.

Janet B. Kim, MD
Allergy

26302 La Paz Rd, #106
Mission Viejo, CA 92691

Dear Allergy Patients,

Certain medications called BETA-BLOCKERS which may be used to control high blood pressure, heart irregularities, migraines, glaucoma, or cataracts may also cause chest tightness in asthmatics or poorly affect allergy injections.

Please inform the allergy injection nurse or physician if you are presently taking, or in the future are placed on any of the following medications which are in the BETA-BLOCKER category.

Systemic Agents (Oral Medications)

Atenolol (Tenormin)
Penbutolol (Levatol)
Esmolol (Brevibloc)
Betaxolol (Kerlone)
Acebutolol (Sectral)
Nadolol (Corgard)
Timolol (Blocadren)
Propranolol (Inderal, Intensol)
Labetolol (Normodyne, Trandate)
Metoprolol (Lopressor)
Sotalol (Betapace)
Carvedilol (Coreg)
Pindolol (Visken)
Bisoprolol (Zebeta)

Ophthalmic Agents (Eye Medications)

Betaxolol (Betoptic)
Timolol (Timoptic)

_____ I do not take any of the above medications.

Patient Name(print)_____

Patient Signature _____

Date _____