HENRY KAW M.D.
321 N Pomona Ave Suite B Fullerton CA 92832

OFFICE POLICY

Welcome and thank you for selecting us for your medical care. This information sheet provides an overview of our office policies. If you have questions regarding our policies, please approach one of our staff members.

INSURANCE AND BILLING

It is your responsibility to understand your insurance benefits. If you are not sure if a service or treatment is covered please contact your insurance carrier. We do not provide information about copayments, coinsurance, or deductible.

It is your responsibility to provide accurate insurance information to this office. Please present your valid insurance identification card(s) at the time of check-in. **Your copayment or coinsurance is required when you check-in.** If there is an additional balance due you will receive a bill from us. You are also responsible for payment of your deductible, and for charges not paid by your insurance carrier(s), which includes denied claims due to lack of information from the subscriber. If you do not have your insurance identification card and a photo ID, you will be asked to pay for your office visit or reschedule to another date. If we are unable to bill your insurance carrier because we did not receive your insurance information in a timely manner, you are responsible for the charges.

We accept many insurance plans. This means we will file your claim for you. This service is provided as a courtesy to you because we value your patronage. We will be happy to submit charges to any secondary or supplemental plans you may have, however, if payment is not received from that firm within 60 days we will issue a bill to you for payment in full.

If we do not accept your insurance plan, payment will be expected when services are rendered. You will be given a bill at time of checkout, which you may file with your insurance carrier for reimbursement. We will accept your payment in cash, check, Visa, and Mastercard.

There is a $50.00 fee for returned checks. 18% per annum interest may be applied to delinquent accounts. Delinquent accounts may be placed with an outside collection agency or pursued through small claims court. You will be responsible for court costs, attorney fees, and/or collection agency fees.

RECEPTION AREA. Seating in our reception area is limited. Please try to limit the number of people who accompany you to your appointment. It may be inappropriate to have small children in the examination room with you. Please do not leave children unattended in the waiting room. **Phone calls, food and/or drinks are not allowed in the waiting area.**

TELEPHONE CALLS. In order to be fair to our scheduled patients, every effort is made not to interrupt the provider/s during patient visits. Patient calls and messages are triaged by staff, and a member of our support staff may return responses to you.

NOTICE OF PRIVACY PRACTICES. 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.

CONTROLLED SUBSTANCE, NARCOTICS, PSYCHOTROPIC MEDICINES – *Before* a new patient with a history of controlled substance prescription use receives the first prescription from us : 1.) patient must provide medical records documenting previous medical work-up regarding the complaint necessitating these prescriptions and notes from previous physicians that prescribed these medications; 2.) must agree to urine comprehensive drug screen 3.) our office will search on California's Prescription Drug Monitoring Program database, (CURES - Controlled Substance Utilization Review and Evaluation System) for the patient's pattern of prescription drug use and, if long-term use is anticipated, 4.) execute a completed controlled substance contract.

PRESCRIPTION REFILLS. Please bring your medicine bottles at each office visit. This will allow us to reconcile medications, as well as check for medications that may be running out. We will gladly refill these medications at the same visit. For prescription refills, please call your pharmacy first as you may have refills remaining and request them to e-request or fax for fastest service. **Please allow <u>two business days</u> for completion of your prescription refill requests that is outside your visit date. To avoid running out of your medications request your prescriptions well in advance of weekends and holidays. It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations will result in a denial of refills. All prescriptions require a follow up appointment every 3 to 6 months, if not sooner.**

APPOINTMENT CANCELLATION.
We are committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. **Please call us AT LEAST ONE BUSINESS DAY prior to your scheduled appointment** to notify us of any changes or cancellations.

PATIENT TERMINATION.
You may be discharged from our office for non-adherence to follow-up visits (two no-shows, consecutive, or several cancellations), treatment plan, office policy, verbal abuse, or non-payment.

I understand that I will be charged a **$50 cancellation fee** for appointments I fail to cancel within 1 BUSINESS DAY.

By signing my name below, I certify that I have read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding of and agreement with the above policies. I understand I am responsible for all charges not paid by insurance. A photocopy of this document is as valid as the original.

_____ _____ _____
Patient (or Guardian)Name Patient (or Guardian) Signature Date

[ ] I would like to receive a copy of this document. [ ] I would like to receive a copy of the Notice of Privacy Practices

HENRY KAW M.D., Inc.
321 N Pomona Ave Suite B Fullerton, CA 92832
P 714 462 8383 F 714 462 8384

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.

AUTHORIZATION

I hereby authorize: Physician/Healthcare Facility _____
Phone Number _____
Fax Number _____

To release information on: (**Patient's Name**) _____
(**Date of birth**) _____

regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: HENRY KAW M.D., Inc.
The medical information/records will be used for the following purpose/s:
[X] Continuity of care [ ] _____
This authorization is:
[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information: _____

I also consent to the specific release of the following records:
Drug/Alcohol/Substance Abuse _____ (initial) Psychiatric/Mental Health _____ (initial)
Tests for Antibodies to HIV _____ (initial) HIV Diagnosis/Treatment _____ (initial)
Genetic Information _____ (initial)

DURATION

This authorization shall be effective immediately and remain in effect for two years from the date of signature below OR (Date) _____.

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of patient or legal/personal representative Relationship (if other than patient)
Patient's Name (Print) _____
Social Security Number _____
Date _____

Witness name (Print) _____
Witness signature _____

HENRY KAW M.D.
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321 N Pomona Ave Suite B Fullerton CA 92832
Phone (714) 462-8383
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Date of Initial Visit
Referred by

Rev. 03.10.19

Patient Information						
Name		Preferred Name	[ ] Male [ ] Female	Social Security No.	Date of birth	Age
Cellphone ( )	Home Phone ( )	Work Phone ( )	Preferred method of communication: [] Cellphone [] Home [] Work [] Email			
Email address		[ ] I wish to sign up for online medical record access and appointment reminders			Preferred language	
Address		City	State	Zip Code	Ethnicity	

Insurance Information			
Guarantor : [] Self [] Spouse [] Child [] Other			
	Insurance Type	Insurance #	Date of Eligibility
Primary Insurance	[] PPO [] Medicare		
Secondary Insurance			

Next of kin contact / Emergency contact Information			
Name		Relationship	
Address	City	State	Zip Code
Cellphone ( )	Home Phone ( )	Work Phone ( )	Preferred method of communication: [] Cellphone [] Home [] Work [] Email

Preferred or Current Pharmacy		
Pharmacy Name	Address	Phone number

Prior and Current Doctors		
Prior Primary Care Physician (PCP):	Specialist/s and Specialty:	Specialist/s and Specialty:
Name	Name	Name
Address	Address	Address
Phone / Fax	Phone / Fax	Phone / Fax

I attest that all information above is true and accurate.
I give permission for Henry Kaw M.D. Inc., to bill my insurance for services rendered as my medical doctor.

To avoid running out of my medications, I agree to request my prescription refills at least 2 business days, as well in advance of weekends and holidays. I understand that it is important to keep my scheduled appointment to ensure that I receive timely refills. I understand that repeated no shows or cancellations will result in a denial of my medication refills.
I understand that all prescriptions require a follow up appointment every 3 to 6 months, if not sooner.

I understand that I will be charged a **$50 fee** for appointments I fail to cancel within 1 BUSINESS DAY.

Signature: _____ Date: _____

PLEASE HAND THIS PAGE TO THE FRONT DESK BEFORE PROCEEDING TO THE NEXT PAGE.

Patients Name: _____

Past Medical History	Time / Year Diagnosed	Time / Year Diagnosed	Time / Year Diagnosed
	[] Hypertension _____	[] Skin disorders _____	[] Cancer _____
	[] High cholesterol _____	_____ _____	_____ _____
	[] Heart Attack _____		_____ _____
	[] Heart Failure _____	[] Thyroid disorder	
		[] Hypothyroidism _____	[] Breast disorders _____
	[] Diabetes _____	[] Hyperthyroidism _____	_____ _____
	[] GERD/Heartburn _____	[] Osteoarthritis _____	[] GYN disorders _____
	[] Ulcer _____		_____ _____
		[] Rheumatoid Arthritis _____	
	[] Asthma _____	[] Lupus _____	[] Serious Accident _____
	[] COPD _____	[] Autoimmune Ds _____	_____ _____
	[] Sleep Apnea _____	_____ _____	
			[] Previous hospitalizations
	[] Stroke _____	[] Mental Illness _____	_____ _____
	[] Seizure _____	_____ _____	_____ _____
	[] Headache _____	[] Drug Dependency _____	_____ _____
	[] Insomnia _____	_____ _____	
	[] Anemia _____	[] Alcoholism _____	
	[] Blood Clots _____	[] Depression _____	
	[] Blood Disorders _____	[] Anxiety _____	

Surgical History	Time / Year Diagnosed	Time / Year Diagnosed	Time / Year Diagnosed
	[] Heart _____	[] Breast _____	[] Orthopedic
	[] Pacemaker _____	[] Uterus _____	[] Hip _____
	[] Stent/s _____	[] Ovary _____	[] Knee _____
	[] Abdominal _____	[] Prostate _____	[] Back _____
	[] Appendix _____	[] Cataract _____	[] _____ _____
	[] Gallbladder _____		[] Others _____

Medications			
Name	Dose (mg)	Dosage (how many times per day)	Diagnosis/es
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
Supplements and Over The Counter Medications			
Name	Dose (mg)	Dosage (how many times per day)	Diagnosis/es
1.			
2.			
3.			

Medication and Food Allergies					
Medication Allergies: [] None			**Food Allergies:** [] None		
Name	Reaction	Date	Name	Reaction	Date

Patients Name: _____

Family History										
	Father	Mother	Brother/s	Sister/s	Aunt/s	Uncle/s	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
Hypertension (Z82.49)										
Heart Attack (Z82.49)										
High cholesterol (Z83.49)										
Diabetes (Z83.3)										
Stroke (Z82.3)										
Osteoporosis (Z82.62)										
Cancer										
Colon cancer (Z80.0)										
Lung cancer (Z80.1)										
Breast cancer (Z80.3)										
Prostate cancer (Z80.42)										
Skin cancer (Z84.0)										
Other _____										

Social History				
Occupation		**Education**	[] Grade school [] High School [] College [] Post graduate [] _____	
Marital Status	[] Single [] Married [] Widowed [] Divorced [] Separated # of children: _____			
Sexual Activity	Current sex partner(s): [] Male [] Female	Sexually active: [] Yes [] No [] Not currently	Birth Control method: [] none needed name: _____	
Drink caffeine	[] Never	[] Yes, cups per day ____		
Alcohol	[] Never	[] Quit ____	[] Daily [] Heavy [] Occasional / Social # drinks/wk : ____	
Cigarette Smoking	[] Never	[] Quit year: _____ # of packs/day ___ # of years ___	[] Current smoker: packs/day ____ # of years ____ Are you interested in quitting? [] Yes [] No Other Tobacco: [] pipe [] cigar [] snuff [] chew	
Recreational Drugs	[] Never	[]Daily	[] Occasional Type/s: _____ Have you ever used needles to inject drugs? [] Yes [] No	

Health Maintenance

Preventive Tests	Year done	Result
PAP smear (female 21-65)	_____	_____
Chlamydia (sexually active, 24)	_____	_____
Hep C screening (1945-65)	_____	_____
Colonoscopy (50-75)	_____	_____
Mammogram (40-74)	_____	_____
Bone Density Scan (65+)	_____	_____

Immunizations		[ ] will bring records
Meningococcal	(>1dose)	_____
HPV	(3 doses)	_____
Hepatitis A	(2/3doses)	_____
Hepatitis B	(3 doses)	_____
Varicella/Chickenpox	(2 doses)	_____
MMR	(2 doses)	_____
Tetanus(Tdap >7y.)		_____
Tetanus(Td booster)		_____
Influenza (yearly)		_____
Shingles/Zoster (>50)		_____
Pneumonia (Prevnar13)		_____
Pneumonia (Pneumovax23)		_____

Advance Directive	**[]** Yes [] No Do you have an advanced directive? http://www.caringinfo.org/files/public/ad/California.pdf
Adult Tuberculosis (TB) Risk Assessment	**[]** Yes [] No History of positive TB test or TB disease **[]** Yes [] No One or more signs and symptoms of TB (prolonged cough, coughing up blood, fever, night sweats, weight loss, or excessive fatigue). **[]** Yes [] No Close contact with someone with infectious TB disease. **[]** Yes [] No Current or former resident or employee of correctional facility, long-term care facility, hospital, or homeless shelter. **[]** Yes [] No Foreign born person* **[]** Yes [] No Traveler to high TB-prevalence country for more than 1 month * *Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.

Patients Name: _____

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PHQ-9 Over the **last 2 weeks**, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	**Not difficult at all**	**Somewhat difficult**	**Very difficult**	**Extremely difficult**

0-5 = mild 6-10 = moderate 11-15 = moderately severe 16-20 = severe **Totals:** _____

GAD-7 Over the **last 2 weeks**, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	**Not difficult at all**	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
Column totals: _____				

0-5 mild 6-10 moderate 11-15 moderately severe anxiety 15-21 severe anxiety **Totals:** _____