PREMIER GENERAL AND COLORECTAL SURGERY, P.A.

JUNUK KIM MD

PERSONAL INFORMATION

NAME _____
LAST NAME FIRST NAME MIDDLE INTIAL

ADDRESS _____
STREET CITY STATE ZIP CODE

HOME PHONE _____ CELL PHONE _____

E-MAIL ADDRESS _____ PREFERRED METHOD OF CONTACT _____

SSN _____ SEX _____ DOB _____ AGE _____ MARITAL STATUS _____

RACE _____ ETHNICITY _____

PATIENT EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____
STREET CITY STATE ZIP CODE

EMERGENCY CONTACT _____ _____
NAME PHONE

INSURANCE INFORMATION

PRIMARY INSURACE COMPANY _____

PATIENT ID # _____ GROUP # _____

SECONDARY INSURACE COMPANY _____

PATIENT ID # _____ GROUP # _____

GUARANTOR INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT _____ RELATION TO PATIENT _____

ADDRESS _____
STREET CITY STATE ZIP CODE

HOME PHONE _____ CELL PHONE _____

SSN _____ SEX _____ DOB _____ AGE _____

EMPLOYER _____

EMPLOYER ADDRESS _____

STREET CITY STATE ZIP CODE

ASSIGNMENT AND RELEASE

I CERTIFIED THAT I, AND/OR MY DEPENDENTS, HAVE INSURACE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO DR. JUNUK KIM ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES REDERED. 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 NAMES PHYSICIAN MAY USE MY HEALTH CARE INFORMATION AND MAY DISLOSE SUCH INFORMATION TO THE ABOVE INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

_____ _____ _____

PRINTED NAME OF PATIENT/GUARDIAN SIGNATURE OF PATIENT/GUARDIAN DATE

PREMIER GENERAL & COLORECTAL SURGERY, P.A.

JUNUK KIM, M.D.

CONSENT FOR TREATMENT

I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR FOLLOWING MY PHYSICIANS RECOMMENDATIONS AND TO DO WHAT IS NECESSARY TO CONTROL AND TREAT MY CONDITION.

I UNDERSTAND THAT THE SOLE RESPONSIBILITY OF MY HEALTH AND WELL BEING IS IN MY HANDS IN VIEW OF THE ABOVE, AND THAT I CANNOT REASONABLY HOLD MY PHYSICIAN RESPONSIBLE IF I DO NOT ADHERE TO HIS RECOMMENDATIONS AND/OR NOT TAKE MEDICATIONS AS I AM INSTRUCTED TO DO SO.

DECLARATION OF FINANCIAL RESPONSIBILITY

I AM RESPONSIBLE FOR PAYMENT. IF FOR ANY REASON MY INSURANCE COMPANY DOES NOT PAY THE CHARGES AT PREMIER GENERAL AND COLORECTAL SURGERY, P.A. I WILL BE LIABLE FOR ALL UNPAID BALANCES. I UNDERSTAND THAT IN AN EFFORT TO EXPEDITE MY CARE AND TO PROVIDE ME WITH BETTER SERVICE, THE DOCTOR MAY CHOOSE TO PERFORM MY OPERTION IN A FACILITY WHERE THEY MAY HAVE OWNERSHIP INTERESTS. THIS IN NO SHAPE OR FORM WILL AFFECT THE MEDICAL CARE PROVIDED TO ME. I ALSO UNDERSTAND THAT I HAVE THE OPTION TO CHOOSE AN ALTERNATIVE LOCATION FOR MY MEDICAL CARE.

SIGNATURE_____

DATE_____

HIPAA NOTICE OF PRIVACY PRACTICES

I AM AWARE OF THE HIPAA NOTICE OF PRIVACY PRACTICES FOR PREMIER GENERAL AND COLORECTAL SURGERY AND THE COPIES OF THE NOTICE ARE AVAILABLE FOR ME UPON REQUEST.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO DESIGNATED PERSONS

I GIVE MY AUTHORIZATION TO RELEASE MEDICAL/SURGICAL INFORMATION TO THE FOLLOWING DESIGNATED RESPRESENTATIVES.

- ☐ MY SPOUSE(NAME)_____
- ☐ MY CHILD(NAME)_____
- ☐ OTHER(NAME)_____
- ☐ MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF

I HEREBY AUTHORIZE MEDICAL INFORMATION TO BE RELAYED TO ME BY PHONE/EMAIL

PHONE_____EMAIL_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ OR HAD THE OPPORTUNITY TO READ IF I SO CHOSE, AND UNDERSTOOD THE NOTICE.

_____

PATIENT NAME (PRINT) DATE

_____

AUTHORIZED REPRESENTATIVE

_____

SIGNATURE

Medical Questionnaire

NAME _____ Height:_____ Weight_____

Who referred you today? Name & Number _____

Who is your primary care doctor? Name & Number _____

What is the reason to see the doctor today? _____

Pharmacy Name & Number: _____

PLEASE CIRCLE IF YOU HAVE OR HAVE HAD ANY OF THESE CONDITIONS

ARTHRITIS	COPD	CORONARY ARTERY DISEASE
Type of CANCER:	DEEP VEIN THROMBOSIS	HIGH CHOLESTEROL
HYPERTHYROIDISM	HYPOTHYROIDISM	OSTEOPOROSIS
DIABETES	BLOOD THINNERS OTHER THAN ASPIRIN	HIGH BLOOD PRESSURE
DIVERTICULITIS	Pulmonary Embolism	KIDNEY DISEASE
FIBROMYALGIA	JAUNDICE OR LIVER DISEASE	GERD/REFLUX
GOUT	LUNG DISEASE (ASTHMA OR EMPHYSEMA)	HEPATITIS

PAIN SCALE:1-10 (10) being the worse:_____ ALLERGIES:_____

PLEASE CIRCLE ALL PROBLEMS YOU HAVE

RECTAL BLEEDING	RECTAL PAIN
CHANGE IN ANY BOWEL HABITS	ABDOMINAL PAIN OR CRAMPS R, L or Bilateral side
CONSTIPATION	DIARRHEA
WEIGHT LOSS	WEAKNESS OR TIREDNESS
FEVER	DIFFICULTY BREATHING
CHEST PAIN	PALPITATION

PLEASE CHECK IF YOU HAVE FAMILY HISTORY . WHAT FAMILY MEMBER HAS IT?

____ COLON CANCER:_____ ____ULCERATIVE COLITIS OR CROHN'S DISEASE: _____

____ COLON POLYPS: _____ ____ BREAST, OVARIAN OR UTERINE CANCER: _____

ARE YOU ALLERGIC TO IODINE? Y/N ARE YOU ALLERGIC TO LATEX? Y/N

PLEASE LIST ANY PREVIOUS SURGERIES OR PROCEDURES DATE AND YEAR.

_____

PLEASE LIST ANY MEDICATIONS & DOSAGE YOU ARE CURRENTLY TAKING_____

_____

SOCIAL HISTORY

DO YOU SMOKE? Y / N IF YES, HOW MUCH A DAY?_____

DID YOU SMOKE IN THE PAST? _____ SINCE WHAT AGE?_____

DO YOU CHEW TOBACCO?_____ 1/DAY _____ 2-4/DAY _____5+/DAY_____

DO YOU DRINK ALCOHOL? Y / N HOW MUCH PER DAY/WEEK?_____

DO YOU USE FIBER SUPPLEMENTS? Y / N

DO YOU USE LAXATIVES? Y / N

DO YOU HAVE ANY LEAKAGE OF GAS, LIQUID OR SOLID STOOLS BY ACCIDENT? Y / N

DO YOU HAVE ANY ANAL DISCHARGE OR LEAKAGE STAINING YOUR UNDERWEAR? Y / N

DOES ANYTHING PROTRUDE OR STICK OUT OF THE RECTUM? Y / N

HAVE YOU EVER HAD A COLONOSCOPY? Y / N

PREMIER GENERAL AND COLORECTAL SURGERY, P.A.

17115 RED OAK DR SUITE 211, HOUSTON, TX, 77090

PHONE/932-303-2922 FAX/281-781-8637

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE **DR. JUNUK KIM** TO ☐ RELEASE TO ☐ RECEIVE FROM

PERSON OR ORGANIZATION _____

ADDRESS _____

PHONE_____ FAX _____

INFORMATION/COPIES FROM THE MEDICAL RECORDS ON

NAME _____ DOB_____

SS# _____ DATE OF SERVICE _____

INFORMATION TO BE RELEASED

☐ EMERGENCY ROOM ☐ RADIOLOGY REPORTS ☐LAB WORK ☐ RADIOLOGY FILM ☐CONSULTATIONS

☐HISTORY AND PHYSICAL ☐PATHOLOGY REPORT ☐ BILLING RECORDS ☐OPERATIVE REPORT

☐DISCHARGE SUMMARY ☐OTHER _____

THE INFORMATION IS BEING RELEASED FOR THE FOLLOWING PURPOSE

☐CONTINUED CARE ☐INSURACE ☐DISABILITY SERVICES ☐ATTORNEY/LITIGATION

☐OTHER _____

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME, ECEPT TO THE EXTENT THAT ATION HAS BEEN TAKEN IN RELIANCE ON IT AND THAT IN ANY EVENT THIS AUTHORIZATION SHALL EXPIRE 180 DAYS FROM THE DATE OF MY SIGNATURE, UNLESS SPECIFIED IN WRITING HERE _____

_____O RECEIVE

I UNDERSTAND THAT IF THE RECIPIENT AUTHORIZED TI\HE INFORMATION IS NOT A COVERED ENTITY, E.G. INSURANCE COMPANY OR NON-HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDRAL AND STATE PRIVACY REGULATIONS.

TO THE PARTY RECEIVING THIS INFORMATION

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM REORDS WHOSE CONFIDENTIALITU MAY BE PROTECTED BY FEDRAL LAW. IF SO, FEDERAL REGULATIONS(43 CFR PART 2) PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF INFORMATION OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.

FOR PATIENT RECORDS APPILICABLE UNDER FEDRAL SAW 43 CFR PART 2

SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE

DATE

PRINTED NAME OF LEGALLY AUTHORIZED REPRESENTATIVE

RELATIONSHIP TO PATIENT

PRINTED NAME AND SIGNATURE OF WITNESS

DRIVER'S LICENSE NUMBER