Dr. Kenson Miyaki

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PATIENT INFORMATION FORM

DATE: ___/____/____

NAME: _____

DATE OF BIRTH: _____/_____/_____ AGE: _____ SEX: _____

HOME ADDRESS: _____

CITY/STATE: _____ZIP: _____

HOME PHONE #: (_____) _____-_____

CELL PHONE #: (_____) _____-_____

E-MAIL: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO
IF YES, NAME: _____ RELATIONSHIP: _____
PHONE #: (_____) _____-_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____
PHONE #: (_____) _____-_____

PRIMARY CARE DOCTOR: _____

PHONE: _____

PHARMACY: _____ LOCATION: _____

PHONE #: (_____) _____-_____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

_____ YES NAME(S)_____

_____ NO

WHO REFERRED YOU TO US?

_____

EMPLOYER/OCCUPATION: _____

HEIGHT:_____ **WEIGHT:**_____

ALLERGIES:

☐ NO KNOWN DRUG ALLERGIES
☐ ALLERGY TO MEDICATIONS_____
☐ FOODS _____
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____

MEDICATIONS (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME OF DRUG/**DOSE**/HOW OFTEN DO YOU TAKE?

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

MEDICAL HISTORY:

HAVE YOU EVER HAD ANY OF THE FOLLOWING? **CHECK BOX THAT APPLIES**

ACID REFLUX			FIBROMYALGIA			NEUROPATHY	
ANEMIA			GOUT			OPEN SORES	
ARTHRITIS			HEART ATTACK			PNEUMONIA	
ASTHMA			HEART ISSUE_____			POLIO	
BACK TROUBLE			HEPATITIS			RHEUMATIC FEVER	
BLADDER INFECTIONS			HIV+/AIDS			SICKLE CELL DISEASE	
ABNORMAL BLEEDING			HIGH BLOOD PRESSURE			SKIN DISORDER	
BLOOD CLOTS			KIDNEY DISEASE			SLEEP APNEA	
BLOOD TRANSFUSION			LIVER DISEASE			STOMACH ULCERS	
BRONCHITIS/EMPHYSEMA			LOW BLOOD PRESSURE			STROKE	
CANCER/TYPE_____			MIGRAINE HEADACHES			THYROID DISEASE	
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)			HIGH CHOLESTEROL			TUBERCULOSIS	
OTHER CONDITIONS:								

SURGICAL HISTORY/ HOSPITALIZATIONS:

TYPE OF SURGERY/DATE OF OPERATION AND ANY HOSPITALIZATIONS/REASON

_____

_____

_____

_____

FAMILY HEALTH/MEDICAL ISSUES:

FATHER_____

MOTHER_____

SIBLINGS_____

SOCIAL HISTORY:

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE

☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐NEVER ☐QUIT(LAST USED)_____ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS:☐ NEVER ☐ QUIT (LAST USED) _____ TYPE _____

☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ **Date:** _____

PATIENT FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

-As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

-Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.

-Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

-We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the copay/coinsurance/deductible.

-If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

-All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

-You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

-For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

-There are certain elective surgical procedures for which we require prepayment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

-Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.

-There is a service fee of $10.00 for all returned checks. Your insurance company does not cover this fee.

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information.

We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

-To family members or close friends who are involved in your health care;

-For certain limited research purposes;

-For purposes of public health and safety;

-To Government agencies for purposes of their audits, investigations and other oversight activities;

-To government authorities to prevent child abuse or domestic violence;

-To the FDA to report product defects or incidents;

-To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;

-When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

-To have access to and/or a copy of your health information;

-To receive an accounting of certain disclosures we have made of your health information;

-To request restrictions as to how your health information is used or disclosed;

-To request that we communicate with you in confidence;

-To request that we amend your health information;

-To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

ASSIGNMENT OF INSURANCE BENEFITS * FINANCIAL AGREEMENT * RELEASE OF MEDICAL INFORMATION

I hereby give authorization for payment of insurance benefits to be made directly to Dr. Kenson Miyaki and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize the above Doctor to release all information necessary to secure the payment of benefits, and for the coordination of care with other health professionals (via hard copy, electronically or Health Information Exchange). I further agree that a photocopy of this agreement shall be valid as the original. I also acknowledge that I have read (or had the opportunity to read if I so chose) and understood the Notice of Privacy Practices, and that a copy could be provided.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ **Date:** _____