Asha Kohli, M.D.

Insurance Verification

Proof of Insurance is required by law

Patient Information:

Name: _____ Date of Birth: _____/_____/_____

Address: _____ Age: _____ M _____ F _____

City, ST, Zip: _____ Home Phone: (_____) _____-_____

S.S. NO.: _____ Work Phone: (_____) _____-_____

Martial Status: S D M W Race: _____ Cell Phone: (_____) _____-_____

Driver's License: _____ Email Address: _____

Emergency Contact: _____ Emergency Contact Phone #: (_____) _____-_____

Insurance Information:

Insurance Co. Name: _____ Identification No: _____

Ins. Phone Number: (_____) _____-_____ Group No: _____

Policy Holder's Name: _____ Policy No: _____

Policy Holder's SSN: _____-_____-_____ Account No: _____

Policy Holder's DOB: _____/_____/_____ Employer: _____

Office Visit Reason: _____ Current Doctor: _____

FOR OFFICE USE ONLY- DO NOT WRITE BELOW LINE

Plan Type: HMO PPO EPO POS OTHER: _____ In Network: _____

Policy Effective Date: _____/_____/_____ Ins. Termed: _____/_____/_____

Office Visit Co-pay: _____ Deductible: _____ Applies: IO Surgery Labs

Designated labs: _____ Notes: _____ % of the allowed amount _____

Wellness Benefits

Routine Physical: _____ How Often: _____ Max $ Amount per Year: _____
EKG _____ BMD _____ Cholesterol _____ PSA _____ PAP _____

Well Woman Exam: _____ How Often: _____ Max $ Amount per Year: _____

Well Child Exam: _____ How Often: _____ Max $ Amount per Year: _____

Immunizations Coverage: _____ Age Limits on Immunizations: _____

Claims Address:

_____

_____

_____

Verified By:

_____

Rep: _____

Date: _____

Our practice participates in electronic prescribing. As such, we will need you to please provide your pharmacy information below:

<u>Local Pharmacy Information:</u>

Pharmacy Name: _____

Pharmacy Phone#: _____

If You Receive Your Prescriptions By Mail We Will Need:

Pharmacy Name: _____

Pharmacy Phone#: _____

Medical History

Date _____

Name _____ Age _____ Birthdate _____

Address _____ Sex ☐ Male ☐ Female

_____ Home Phone _____

_____ Work Phone _____

Occupation _____ Emergency Contact _____

Phone _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If married, spouse's name _____

Children's names and ages _____

Allergies to Medications, X-Ray Dyes, or Other Substances ☐ No ☐ Yes

(If yes, please list name of medicine and type of reaction)

Past Medical History and Review of Systems

Please check off if **you** have had any problems with or are presently experiencing any of the following:

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Chest pain/chest tightness
- ☐ Shortness of breath
- ☐ Swollen ankles
- ☐ Palpitations
- ☐ Lightheadedness
- ☐ Frequent urination
- ☐ Rheumatic fever
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Persistent cough
- ☐ T.B.
- ☐ Hay fever
- ☐ Abdominal discomfort
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Ulcers
- ☐ Change in bowel habits
- ☐ Unexplained weight gain/loss
- ☐ Hemorrhoids
- ☐ Gall Bladder disease
- ☐ Colitis
- ☐ Hepatitis or jaundice
- ☐ Thyroid disease
- ☐ Head or neck radiation
- ☐ Headache
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Difficulty urinating
- ☐ Arthritis
- ☐ Low back problems
- ☐ Skin diseases
- ☐ Blood disorders
- ☐ Venereal diseases
- ☐ Anxiety
- ☐ Depression
- ☐ Anemia
- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ Gout
- ☐ Impotence or Erectile Dysfunction
- ☐ Other

Gynecologic and Obstetric History

Age at onset of periods _____ Frequency _____ Length of period _____

Pregnancies _____ Births _____ Miscarriages _____

Prolonged or abnormal bleeding ☐ No ☐ Yes (Please describe) _____

Leakage of urine ☐ No ☐ Yes (Please describe) _____

Pelvic pain ☐ No ☐ Yes (Please describe) _____

Abnormal discharge ☐ No ☐ Yes (Please describe) _____

History of abnormal Pap smear ☐ No ☐ Yes (Please describe) _____

This information is for use by your physician as part of your confidential medical record.

Please continue on the next page

Medical History

Name _____ Date _____

Please List and Supply the Dates of:

Operations _____ _____ _____

_____ _____ _____

Hospitalizations other than for surgery _____ _____

_____ _____ _____

Immunization history—have you had:

Hepatitis B? ☐ No ☐ Yes When? _____

Other? ☐ No ☐ Yes When? _____

Pneumovax immunization? ☐ No ☐ Yes When? _____

Flu immunization? ☐ No ☐ Yes When? _____

Tetanus immunization? ☐ No ☐ Yes When? _____

When was your last:

Pap Smear? _____ Breast Exam? _____ Colon Cancer Test? _____

Mammogram? _____ Cholesterol check? _____ Prostate exam? _____

Family History Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Age when diagnosed
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart Disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc.)		
Drug or alcohol addiction		
Glaucoma		
Bleeding diseases		
Other _____		

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose	Drug Name	Dose

Prevention

Do you wear seat belts?	☐ Yes	☐ No	If no, why not? _____
Do you wear a bike helmet?	☐ Yes	☐ No	☐ N/A
Do you exercise regularly?	☐ Yes	☐ No	If yes, type, duration and number of times per week? _____
Do you smoke?	☐ No	☐ Yes	If yes, how many packs per day? _____
Do you drink alcoholic beverages?	☐ No	☐ Yes	If yes, how much per week? _____
Do you drink coffee?	☐ No	☐ Yes	If yes, how many cups per day? _____
Do you drink tea?	☐ No	☐ Yes	If yes, how many cups per day? _____
If there is a gun in your home, do you keep it unloaded and out of children's reach?	☐ Yes	☐ No	☐ N/A
Do you use drugs? (marijuana, cocaine, crack, etc.)	☐ No	☐ Yes	If yes, explain: _____
Have you ever engaged in any activity which has put you at risk of getting AIDS?	☐ No	☐ Yes	If yes, explain: _____
Do you wish to be tested for AIDS?	☐ No	☐ Yes	
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials?	☐ No	☐ Yes	If yes, explain: _____
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner?	☐ No	☐ Yes	
Do you ever feel afraid of your partner?	☐ No	☐ Yes	☐ N/A
Do you have a "living will"?	☐ Yes	☐ No	
Do you have a donor card?	☐ Yes	☐ No	

Method of birth control? _____

This information is for use by your physician as part of your confidential medical record.

PATIENT CONSENT FORM

Asha Kohli, M.D., P.A.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Asha Kohli, M.D. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by Asha Kohli, M.D. describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing the consent. Asha Kohli, M.D. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our office.

With this consent, Asha Kohli, M.D. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Asha Kohli, M.D. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Asha Kohli, M.D. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patients statements. I have the right to request that Asha Kohli, M.D. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bounded by this agreement.

By signing this form, I am consenting to allow Asha Kohli, M.D. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Asha Kohli, M.D. may decline to provide treatment to me.

Signed By: _____ _____ _____

Signature of Patient or Legal Guardian Date Relationship to Patient

_____ _____

Print Patients Name Print Name of Legal Guardian

Patient/Guardian must be provided with a signed copy of this authorization form.

ASHA KOHLI, M.D.

Diplomate, American Board of Family Practice

Welcome,

We are committed to providing you with quality medical care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or responsibility.

Missed appointments: Our policy is to charge $25.00 for **missed appointments not cancelled within a reasonable amount of time.** These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointments. To assist us in establishing your account please (1) provide current insurance information on our new patient registration form, and (2) authorize release of information necessary for insurance filing and pre-certification (sign below). Failure to do so will affect our financial responsibility for charges incurred. Your payment can be in the form of cash, check, or credit card.

REGARDING INSURANCE

Each time you make an appointment it is your responsibility to make sure this office is currently under contract with your plan and, if required, you have chosen Asha Kohli, M.D. as your Primary Care Physician. Certification of your plan is required. Often this verification requires us to share the reasons for your visit with your managed care plan. Please plan to show your current card to our staff upon request. Co-payment, co-insurance, deductibles, and/or fees for non-covered services are required at time of service.

Insurance is a contract between you and your insurance company. We are not a party to your contract. We will not become involved in disputes between you and your insurance company, regarding deductibles, non-covered/ covered charges, co-insurance, secondary insurance, coordination of benefits, pre-existing conditions, or "reasonable and customary" charges, other than to supply factual information as necessary. You are responsible for the timely payment of your account.

Some services performed in our office are considered surgical procedures by your insurance company. These services may be covered by your insurance company, but may be subject to a deductible or co-insurance. Any deductible, co-insurance, or non-covered service is your responsibility to pay, and we may ask for payment at time of service. Surgical procedures may include, but are not limited to: treatment of warts; removal of moles, cysts; drainage of abscesses; nail plate removal; and blood work.

After 60 days, it is the patients' responsibility to pay the balance of the account even if there is an insurance claim pending. We will not longer be responsible for collecting your insurance claim or for negotiating a settlement of a disputed claim.

I have read and understand the above terms and conditions and will verify so by giving my signature.

Patient/Responsible Party: _____ Date: _____

ASSIGNMENT: I hereby authorize payment directly to this office. Any changes to this authorization must be received in writing within 30 days or the effective date.

Patient/Responsible Party: _____ Date: _____

I agree to the release of any and all medical information, including test results, any financial information necessary to process this and any future claims to my insurer or payer of health benefits, as I may designate that person or entity form time to time, for an indefinite period or until I submit a written revocation of this release. Any changes to this authorization must be received in writing within 30 days of effective date.

Patient/Responsible Party: _____ Date: _____