Kim P. Kuhar, D.O.
Niccole Oswald, M.D.

KUHAR MEDICAL
Internal Medicine, PC • Cosmetic Services

Polly James, CRNP
Kathryn Cunningham, PA-C

164 West Main Street • Silverdale, PA 18962
Phone: 215.258.3810 • Fax: 215.258.3815

WELCOME TO DR. KIM KUHAR, D.O. INTERNAL MEDICINE, P.C.

We are delighted that you have chosen our practice to assist you with your health care needs. In order to better serve our new patients, we have enclosed forms that need to be completed prior to your office visit. Please complete the 2 Medical History forms, our Notice of Patient Privacy Rights form, our Cancellation Policy and our HIPPA Privacy form. A form for Medical Records release is also included if you have records from a previous doctor.

We also request that you provide your medical insurance cards. Our receptionist will scan the card and your insurance information into our computer during our check-in process. If your health insurance requires a co-pay, or you have a deductible you will be required to pay at the time of your visit. We accept Cash, Check and Credit cards (Visa, Master Card and Discover) are accepted.

Please bring along any previous medical records or recent testing that you have. Any previous medical information is always beneficial for the doctors to have in diagnosing your treatment.

Due to changes in law, for your protection against identity theft, we are asking that you bring a photo ID to your visit. If you do not have a photo ID, please bring a recent bill containing your name and address.

If you have any forms to be filled out, (School, Work, Sport, CDL physical, MA51, Disability, Nursing Home admission or Pre-Op Clearance)please bring them along at the time of your visit. We charge an Administrative fee for completing these forms.

As a friendly reminder, we will contact you at least two days in advance to confirm your appointment.

We look forward to meeting you! If you have any questions regarding the completion of the enclosed forms, please do not hesitate to contact our office. Our friendly and courteous staff will be available to assist you Monday thru Friday from 8am-4:30pm.

Sincerely,
Physicians and Staff of Dr. Kim P. Kuhar, DO Internal Medicine, P.C.

Notice of Privacy Practices

Patient's Name: ____ (please print)

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and Amended March 2013.

Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.
We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain circumstances:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or to the public. We will only make disclosures to a person or organization able to prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For workers Compensation and similar programs.
9. For treatment purposes including sharing medical data with another provider, making referrals, placing lab or prescription orders.
10. For payment purposes, for filing claims either by paper or electronically.
11. For Health care operations, for quality assurance, utilization reviews, credentialing, underwriting and auditing.

Your rights regarding your health information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable request.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment if paid out of pocket for certain care or health care operations. Additionally, you have the right to request that we restrict our disclosure for your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when information is necessary to treat you.
3. You have the right to obtain a copy of the health information that may be used to make decisions about you, including patient paper and electronic medical records and billing records, but not including psychotherapy notes. We the practice has 30 days to respond to your request, and to charge an administrative fee of at least $25.00 for this copy.
4. You must submit your request in writing with the name of your treating physician to the practices Privacy Official, Eileen Roetman, or to her designee who can be reached at (215) 258-3810 if you need further information.
5. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as it is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the practices Privacy Official, Eileen Roetman, who can be reached at (215) 258-3810 if you need further information.
6. You have the right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the practices Privacy Official, or her designee at (215) 258-3810.
7. Right to file a complaint with our practices Privacy Official or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the practices Privacy Official, Eileen Roetman who can be reached at (215) 258-3810. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. Right to provide an authorization for other uses and disclosures. Our practice will obtain you written authorization for uses and disclosures of Psychotherapy notes, or protected health information that the office uses for Marketing and any other protected health information that are not identified by this notice or permitted by applicable law.
9. You have right to be notified in writing upon a breach of any of your unsecured PHI
10. You have a right to opt out of getting fundraising communications from our office.

Patient Signature: ___________________________ **Date:** ________________________

Authorization for Release of Medical Records

Patient Name:____

Patient Address:____

Patient DOB:____

Telephone Number:_________________Social Security Number:__________________

I authorize the records to disclose/release the following information**(Check all applicable)

_____ All Records

_____ Laboratory/Pathology Results

_____ X-ray/Radiology Records

_____ Office Notes

_____ Other:______________________

**Note: If these records contain any information about drug/alcohol abuse, sexually transmitted disease, or psychiatric issues, you are hereby authorizing disclosure of this information.

Please release the records FROM:

____

(Complete name of Person/Organization)

____

Address

____

City, State, Zip Code

____

Phone Number/Fax Number

And send Records TO:

Kim P. Kuhar, D.O. Internal Medicine, PC
164 W. Main St., PO Box 420
Silverdale, PA 18962
Phone (215)258-3810 Fax (215)258-3815

By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information.

____ ____________________

Signature of patient or patient's representative Date

MEDICAL HISTORY

Name:______________________________________
Address:____________________________________
____
____
Occupation:_________________________________
Social Sec.#:________________________________
Single Married Divorced Widowed Separated
If Married, Spouse's Name__________________________

TODAY'S DATE:_____________________________
Age________ Date of Birth:____________________
Sex: Male__________Female___________
Home Phone:_________________________________
Work Phone:_________________________________
Emergency Contact:___________________________
Emergency Contact Phone:______________________
Who referred you to our office?_________________
Children Names & ages_______________________________

____

Allergies to Medications, X-ray Dyes, or Other Substances (If yes, please list name of medicine and type of reaction)
____
____

Social History

Do you presently smoke? YES NO
Do you use any illicit drugs? YES NO
Have you ever been a significant smoker? YES NO
How much alcohol do you drink weekly? ________________

Past Medical History and Review of Systems

Please circle if you have had problems with or are presently complaining of any of the following:

1. High Blood Pressure
2. Diabetes Diseases
3. Cancer
4. Heart disease
5. Chest pain/tightness
6. Shortness of Breath
7. Swollen ankles
8. Palpitations
9. Lightheadedness
10. Frequent Urination
11. Rheumatic Fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent Cough
16. T.B.
17. Hay Fever
18. Abdominal discomfort
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23. Diarrhea
24. Blood in Stool
25. Ulcers
26. Change in Bowel Habits
27. Unexplained weight gain/loss
28. Hemorrhoids
29. Gall bladder disease
30. Colitis
31. Hepatitis or Jaundice
32. Thyroid disease
33. Head or Neck radiation
34. Headache
35. Kidney Disease
36. Kidney Stones
37. Difficulty urinating
38. Arthritis
39. Low back problems
40. Skin disease
41. Venereal
42. Anxiety
43. Blood Disorders
44. Depression
45. Anemia
46. Alcohol abuse
47. Drug abuse
48. Gout

____
____
____

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:_____________________________________

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

Drug Name	**Dose**	**Drug Name**	**Dose**

Please List and Supply the Dates of:

Operations:____

____

____

Hospitalizations other than for
surgery:____

____

Immunization History: **(Have you had any of the following & if so, when?)**

Pneumovax Immunization ___YES___NO___________ Hepatitis A___YES___NO_________________

Influenza Immunization ___YES___NO___________ Hepatitis B___YES___NO_________________

Tetanus Immunization ___YES___NO___________ Varicella ___YES___NO_________________

Tuberculosis Test ___YES___NO___________ MMR ___YES___NO_________________

Other?____
___

Routine Exams: **(Have you had any of the following & if so, when?)**

Mammogram ___YES___NO ___________ Breast Exam ___YES___NO______________________

DexaScan ___YES___NO____________ PAP Smear ___YES___NO______________________

Cholesterol Check ___YES___NO____________ Colonoscopy ___YES___NO______________________

Prostate Exam ___YES___NO____________ EKG ___YES___NO______________________

Stool Check for Blood___YES___NO________________

Family History

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

Illness *Which Family Member(s)?* *Approx. Age when diagnosed?*

Cancer(Describe type) ____

Hypertension ____

Heart Disease ____

Diabetes ____

Strokes ____

Mental Disease(anxiety, depression, etc.)____

Drug or Alcohol Addiction ____

Glaucoma ____

Colon Polyps ____

Are your parents still alive? ___YES___NO If so, age?____

Prevention

Do you wear seatbelts? ___YES___NO If no, why not?____________________________________

Do you wear a bike helmet? ___YES___NO ___N/A

Do you drink coffee? ___YES___NO If yes, how many cups per day?__________________________

Do you drink tea? ___YES___NO If yes, how many cups per day?__________________________

Is there a gun in your home? ___YES___NO ___N/A

Have you ever engaged in any activity which
has put you at risk of getting AIDS? ___YES___NO If yes, explain.__________________________

Do you wish to get tested for AIDS? ___YES___NO __________________________

Have you ever worked with chemicals, paints,
asbestos, or hazardous materials? ___YES___NO? If yes, explain.__________________________

Are you in a relationship where you
have been physically hurt?(ex. Slapped, kicked, punched, bruised? ___YES___NO

Do you ever feel afraid of your partner? ___YES___NO___N/A

Do you have a living will? ___YES___NO

Do you have a donor card? ___YES___NO

Method of Birth Control? ___YES___NO Explain.____

*****This information is used by your physician as part of your confidential medical record.*****

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FINANCIAL POLICY

PATIENT'S NAME: ______________________________

Thank you for choosing as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

- **All patients must complete our Information and Insurance forms before seeing the doctor.**
- **FULL PAYMENT OF PATIENT RESPONSIBILITY IS DUE AT TIME OF SERVICE.**
- **We accept cash, checks, money orders, and credit cards.**
- **Insurance cards must be presented at initial visit, or patient will need to reschedule.**
- **All copays, deductibles, and payment of non-covered services are due prior to treatment.**

Regarding Insurance:

Non-Participating

Payment for services is due at the time the services are rendered unless payment arrangements have been approved by our billing company. We will be happy to help you process your insurance claim form for your reimbursement. A completed insurance form must accompany any such request at each visit. In special instances, we may accept assignment of insurance benefits. Regardless of any prior arrangements, you are responsible for any out of pocket deductible or co-insurance and these amounts must be paid up front. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. ***If your insurance company has not paid your account in full within 31 days, the balance will be automatically transferred to you.***

Participating

Please be aware that some, and perhaps all, of the services provided may be non-covered services. It is our policy not to perform those services unless deemed medically necessary.

Usual and Customary Rates/Non Participating

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Missed Appointments

Unless canceled 24 hours in advance, unless the cancellation was for an emergency, i.e. hospitalization. Our policy is to charge for missed appointments at the rate of $ 40 per missed appointment. Please help us serve you better by keeping scheduled appointments

- I acknowledge full responsibility for services rendered by Kim P. Kuhar, DO, PC.
- I understand that payment of charges incurred is due at time of service unless other financial arrangements have been made prior to treatment.
- I further authorize and request that payments be made directly to Kim P. Kuhar, DO, PC
- If my insurance prohibits direct payment to a doctor, I hereby instruct and direct you to make out the check to Kim P. Kuhar, DO, PC and mail it as follows: 164 W.Main Street, Silverdale, PA 18962
- I have read the Financial Policy, understand it, and agree to the terms of this Financial Policy.

Patients Signature: ______________________________ **Date:** ______________________

Print Patients Name: ______________________________

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MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Kim Kuhar, Do Internal Medicine. When you schedule an appointment with our practice we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective August 1, 2018 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours' notice** will be considered a No Show and charged a **$40.00 fee**.
- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a **second** time will be charged a **$60.00 fee**.
- If a **third,** No Show or cancellation/reschedule with no 24-hour notice should occur the patient may be **dismissed** from the practice.
- Any new patient who fails to show for their initial visit will not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is **due prior to the time of the patient's next office visit**.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Front office Supervisor, Dawn Balint to discuss and she may be able to waive the No Show fee.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

______________________________ ______________________________
Signature Printed Name

______________________________ ______________________________
Staff Witness Signature Date

American Board of Internal Medicine®

American Board of Family Medicine