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

KUHAR MEDICAL
Internal Medicine, PC • Cosmetic Services

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

Polly James, CRNP
Melissa Wagner, CRNP

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.

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Patient's Name: _____ *(please print)*

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.

Patients Signature:_____ **Date:**_____

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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.

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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
165 W. Main Street, PO Box 420
Silverdale, PA 18962
P: 215.258.3810 | F: 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

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Polly James, CRNP
Melissa Wagner, CRNP

Name:_____
Address: _____
_____
_____
Occupation:_____
Social Sec #:_____
Single | Divorced | Widowed | Separated
If Married, Spouse's Name_____

Age:_____ Date of Birth:
_____
Sex: Male | Female
Home Phone:_____
Work Phone:_____
Emergency Contact:_____
Emergency Contact Phone:_____
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
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:_____ Birth:_____

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	Drug Name
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

American Board of Internal Medicine®

American Board of Family Medicine

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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 discovered?*
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(s)? _____

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?			If yes, explain _____

Are you in a physically abusive relationship?	___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	If yes, 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

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PARTICIPATING IN A NEW PROGRAM TO ENHANCE YOUR CARE: PRIMARY CARE FIRST

Primary Care First is an innovative healthcare payment program that aims to improve our patients' care experience.

Giving doctors extra support to help you get better care
Our goal has always been to provide you with the highest quality of care. Through Primary Care First, we will receive additional resources from Medicare and other health insurance companies to help us enhance our work and provide you the best quality, patient-centered care.

More information for patients with original Medicare
As part of this program, Medicare will start sharing some of your personal health information with us, such as when you receive care at hospitals, emergency departments, and specialist offices. This will help provide us with a more complete picture of your health and allow us to better coordinate your care.

If you want to stop Medicare from sharing this information, you should call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Your Medicare benefits are not changing, and this program is only intended to enhance the healthcare you receive at Kuhar Medical. You still have the right to use or visit any doctor or hospital that accepts Medicare, at any time. Your doctor may continue to recommend that you see particular doctors for your specific health needs, but it is always your choice which doctors you use or hospital you visit.

Questions?
If you have questions or concerns, you can bring it up at your next appointment.

For more information about this new Medicare program, please:
- Visit the Primary Care First webpage; or
- Call 1-800-MEDICARE.