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

164 West Main Street • Silverdale, Pa 18962 Phone: 215.258.3810 • Fax: 215.258.3815 Polly James, CRNP Melissa Wagner, FNP. 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.

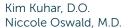
We look forward to meeting you! If you have any questions regarding the completion of the enclosed forms, please do not hesitate to contact our office. Our friendly and courteous staff will be available to assist you Monday thru Friday from 8am-4:30pm.

Sincerely,

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







Polly James, CRNP Melissa Wagner, FNP. CRNP

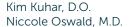
Patient's Na	me: (please print)
Your rights	regarding your health information:
r	Communications. You can request that our practice communicate with you about your health and elated issues in a particular manner or at a certain location. For instance, you may ask that we ontact you at home, rather than work. We will accommodate reasonable request.
F r i: r	You can request a restriction in our use or disclosure of your health information for treatment, buyment if paid out of pocket for certain care or health care operations. Additionally, you have the light 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.
a i:	You have the right to obtain a copy of the health information that may be used to make decisions bout 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 in administrative fee of at least \$25.00 for this copy.
F	You must submit your request in writing with the name of your treating physician to the practices Privacy Official, Michelle Mountz, or to her designee who can be reached at 215.258.3810 if you need urther information.
l. v 2 6. Y F	You may ask us to amend your health information if you believe it is incorrect or incomplete, and as ong 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, Michelle Mountz, who can be reached at \$15.258.3810 if you need further information. 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, ontact the practices Privacy Official, or her designee at 215.258.3810.
H (tight 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, Michelle Mountz who can be reached at 215.258.3810. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
a t	tight to provide an authorization for other uses and disclosures. Our practice will obtain you written uthorization for uses and disclosures of Psychotherapy notes, or protected health information that he office uses for Marketing and any other protected health information that are not identified by his notice or permitted by applicable law.
9. Y	ou 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:



Polly James, CRNP Melissa Wagner, FNP. CRNP

NOTICE OF PRIVACY PRACTICES

Patient's Name:		(please	print)
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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:

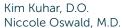
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

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 I	Medical Records		
Patient Name:			
Patient Address:			
Patient DOB:			
Telephone Number:Social Secu			
I authorize the records to disclose/release the following inf	ormation**(Check all applicable)		
All Records			
Laboratory/Pathology Results			
X-ray/Radiology Records			
Office Notes			
Other:	_		
Please release the records FROM:	And send records TO:		
(Complete name of person/organization)	Kim P. Kuhar, D.O. Internal Medicine, PC 164 W. Main Street, PO Box 420		
Address	Silverdale, PA 18962 P: 215.258.3810 F: 215.258.3815		
City, State, Zip Code			
Phone Number/Fax Number			
By signing below, I represent and warrant that I have author	ority to sign this document and authorize		
the use or disclosure of protected health information.			



Signature of patient or patient's representative



Date



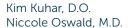
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Name:			Age: D	ate of Birth:		
Address:						
			Sex: Male Female			
			Home Phone:			
Occupation:			Work Phone:			
Social Sec #:			Emergency Contact:			
Single Divorced Wido		parated	Emergency Contact Phone:			
If Married, Spouse's Name		•				
ii mairied, opodoe o maire			Children Names & ages			
Allergies to Medications, X-ray D	yes, or Other	Substances (I	If yes, please list name of medicine and typ	pe of reaction)		
<u>Social History</u> Do you presently smoke?	YES NO		Have you ever been a significant	t smoker? YES NO		
	YES NO		How much alcohol do you drink			
			-			
Past Medical History and Review		.1	1			
Please circle if you have had proble	ms with or are	presently cor	nplaining of any of the following:			
1. High Blood Pressure	13. Bronchit		25. Ulcers	37. Difficulty urinating		
2. Diabetes	14. Pneumo		26. Change in bowel habits	38. Arthritis		
3. Cancer	15. Persister	nt Cough	27. Unexplained weight gain/loss	39. Low back problems		
4. Heart Disease	16. T.B.		28. Hemorrhoids 29. Gall bladder disease	40. Skin disease		
5. Chest pain/tightness6. Shortness of breath	17. Hay Fev	nal discomfort	30. Colitis	41. Venereal 42. Anxiety		
7. Swollen ankles	19. Indigest		31. Hepatitis or Jaundice	43. Blood disorders		
8. Palpitations	20. Nausea	1011	32. Thyroid disease	44. Depression		
9. Lightheadedness	21. Vomiting	g	33. Head or neck radiation	45. Anemia		
10. Frequent Urination	22. Constipa		34. Headache	46. Alcohol abuse		
11. Rheumatic Fever	23. Diarrhea		35. Kidney disease	47. Drug abuse		
12. Asthma	24. Blood in	stool	36. Kidney stones	48. Gout		
Gynecologic and Obstetric Histor	v					
Age at Onset of Periods:	•		Frequency:	Length of		
Pregnancies:Birth			Period:			
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, He				
Drug Name			Drug Name			

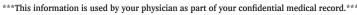






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Please list and supply the dates of:						
Operations:						
Hospitalizations other than for surgery:						
<u>Immunization History:</u> (Have you had an	y of the follo	owing &	if so, when?)			
Pneumovax Immunization	YES	NO		Hepatitis A	YES	NO
Influenza 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	e following 8	k if so, w	hen?)			
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				
Hypertension Heart Disease Diabetes Strokes Mental Disease (anxiety, depression, etc.) Drug or Alcohol Addiction						
Glaucoma						
Colon Polyps	NO			:()2		
Are your parents still alive?YES	NO			if so, age(s)?		
Prevention: Do you wear seatbelts? Do you wear a bike helmet? Do you drink coffee? Do you drink tea? Is there a gun in your home?	_YES _YES _YES _YES	_NO _NO _NO _NO _NO	•	not? many cups per day?_ many cups per day?_		
Have you ever engaged in any activity which	ı:					
Has put you at risk of getting AIDS? Do you wish to get tested for AIDS? Have you ever worked with chemicals, pair	_YES _YES nts, asbestos	_NO _NO s, or haz	ardous materials?	If yes, explain		
Are you in a physically abusive relationship Do you ever feel afraid of your partner? Do you have a living will? Do you have a donor card? Method of high control?	o? 	_YES _YES _YES _YES	NON/ANONONONO	If you ovulain		
Method of birth control?		_YES	NO	If yes, explain		









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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.

and agree to its terms.					
Signature	Printed Name				
Staff Witness Signature	Date				

I have read and understand the Medical Appointment Cancellation/No Show Policy





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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 <u>Primary Care First webpage</u>; or
- Call 1-800-MEDICARE.



