K Alex Kim, MD, A Medical Corporation
Brooks Surgery Center Medical Associates
9001 Wilshire Blvd. Suite 202
Beverly Hills, CA 90211

WELCOME TO THE PRACTICE OF DR K. ALEX KIM

Please provide the following information to help us serve you.

PERSONAL INFORMATION

Last Name ____________________ First Name ____________________ Date ____________________

Date of Birth ______________ Sex: ❏ M ❏ F Marital Status: ❏ single ❏ married ❏ divorced ❏ widowed

Social Security Number ____________________ Driver's License # ____________________

Address: Street ____ Apt____________

City ____________________ State________ Zip ________ Home Phone____________________

Cell Phone____________________ E-mail Address ____

EMPLOYER

Company Name____________________ Occupation/Job Title____________________

Work Address: Street ____________________City ____________ State _____ Zip ________

Work Phone____________________ ❏ Full time ❏ Part time Years Employed__________

EMERGENCY CONTACT

Name____________________Relationship____________Phone____________

Address: Street ____

City ____________________ State ________ Zip ________

REFERRAL

Who should we thank for referring you? ____

May we send you appointment reminders and office news via email? ❏ yes ❏ no

INSURANCE INFORMATION (if applicable)

Please list any and all insurance and/or employee health care plan coverage you or your spouse may have.

Insurance Company/Health Care Plan____

Policy/Group Number ____________________ Effective Date____________________

Name of Insured____________________ Relationship to Insured____________________

If you have HMO/Managed Care Plan, please provide your primary/referring physician information.

Primary Physician/Referring Physician ____________________ Phone ____________________

Spouse Coinsurance Information

Insurance Company/Health Care Plan____

Policy/Group Number ____________________ Effective Date____________________

Name of Insured____________________ Relationship to Insured____________________

MEDICAL LEGAL INFORMATION (if applicable)

Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury **someone else might be legally liable for**? ❏ yes ❏ no Your initials ________

If you answered yes, please fill out accident specific form, available at the front desk.

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X ____

Signature of patient or parent if minor Date

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COMMUNICATION ACKNOWLEDGEMENT - CONSENT

There are many ways to communicate with you. It is important to keep appointments and let us know if problems or issues arise. Methods of communicating are by telephone, text, social media, pager, answering service if available, email, and regular mail. If an emergency arises, keep us alerted to your progress so we may aid in any necessary treatments. Please do not leave a message after hours or on weekends on the office answering machine if any urgent or emergent situation exists, as there is a delay in retrieving such messages. All attempts will be made to preserve your privacy in accordance with HIPAA rules.

Please confirm below all acceptable ways of communicating with you:

____ Telephone

    ____ Home (-   -   )

    ____ Work (-   -   )

    ____ Cell (-   -   )

____ Text (-   -   )

____ Social Media – Facebook, etc.

____ Pager – Answering Service if available

____ Email – with up to date email address (@   )

____ Regular Mail and Delivery

X ____

Signature of patient or parent if minor   Date

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PATIENT'S MEDICAL HISTORY FORM

Patient Name:_______________________________________ Birth Date: ___________________________

Please answer all of the questions as accurately as possible. If you do not understand the question please ask for assistance.

Primary Care Doctor: ____

Smoking (type & amount per day) ________________ Alcohol (type and amount per week)___________________

If former smoker, date quit _______________________ Weight _________________ Height __________________

Drug Allergies: ____

Past surgeries (including cosmetic surgery) or major illnesses and dates: none or list here ___________________________________

____

List any medications you are taking, including non-prescription drugs, vitamins, and herbals: _____________________________________

____

Family History: Has any blood relative ever had the following.

Breast Cancer…..	no	yes	High Blood Pressure…..	no	yes	Kidney Disease…..	no	yes
Melanoma…..	no	yes	Heart disease…..	no	yes	Depression…..	no	yes
Stroke…..	no	yes	Diabetes…..	no	yes	Tuberculosis…..	no	yes

Past Medical History: Have you ever had the following.

Heart disease…..	no	yes	Cancer…..	no	yes	Stomach Ulcer…..	no	yes
Arthritis…..	no	yes	Glaucoma…..	no	yes	Kidney disease…..	no	yes
Rheumatoid fever…..	no	yes	Asthma…..	no	yes	Thyroid disease…..	no	yes
Anemia…..	no	yes	AIDS or HIV+…..	no	yes	Bleeding tendency…..	no	yes
Tuberculosis…..	no	yes	Stroke…..	no	yes	Mitral valve prolapse….	no	yes
Diabetes…..	no	yes	Hepatitis…..	no	yes	High blood pressure…..	no	yes

Review of Systems: Do you have now or have you had within the past year.

Weight change…..	no	yes	Swollen feet/ankles…..	no	yes	Seizures…..	no	yes
Dry eyes…..	no	yes	Skin rash…..	no	yes	Joint or muscle pain…..	no	yes
Chronic cough…..	no	yes	Chronic diarrhea…..	no	yes	Swollen lymph nodes….	no	yes
Chest pain…..	no	yes	Jaundice…..	no	yes	Easy bleeding……	no	yes
Rapid heart rate…..	no	yes	Depression…..	no	yes	Easy bruising…..	no	yes

Women only:

Age period began __________ Number of pregnancies ___________

Date of last mammogram ___________________ Did you breast feed? no yes

Do you do regular breast self-examinations? no yes Breast lump or discharge no yes

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X ____ _________________________________

Signature of patient or parent if minor Date

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Effective April 14, 2003

NOTICE OF PRIVACY PRACTICES (HIPAA Notice)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES

Treatment

Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

Payment

Your health information may be used to seek payment from your health plan, from other sources of coverage such as a automobile insurer, worker's compensation insurance, or from credit card companies that you may use to pay for services.

Health care operations

Your health information may be used as necessary to support the day-to-day activities and management of the office of K. Alex Kim, M.D. and Brooks Surgery Center.

Law enforcement

Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public health reporting

Your health information may be disclosed to public health agencies as required by law.

Other uses and disclosures require your authorization

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of authorization. However, our decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders

Your health information will be used by our staff to send you appointment reminders.

Information about treatments

Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. These include: The right to request restrictions on the use and disclosure of your protected health information; the right to receive confidential communications concerning your medical condition and treatment; the right to inspect and copy your protected health information; the right to amend or submit corrections to your protected health information; the right to receive an accounting of how and to whom your protected health information has been disclosed; the right to receive a printed copy of this notice.

DUTIES OF K. ALEX KIM, M.D. AND BROOKS SURGERY CENTER

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in the notice.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting my office staff. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to our office.

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

I hereby acknowledge that I have been presented with a copy of Notice of Privacy Practice adopted by the office of K. Alex Kim, M.D. and Brooks Surgery Center.

Signature ____ Date: _______________

Rev. 04/03

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STATEMENT OF FINANCIAL RESPONSIBILITIES

Financial Responsibilities:
The cost of surgery involves several charges for the services provided. The total includes fees charged by your surgeon, the cost of surgical supplies, anesthesia, laboratory tests, and possible outpatient hospital charges, depending on where the surgery is performed. Depending on whether the cost of surgery is covered by an insurance plan, you will be responsible for necessary co-payments, deductibles, and charges not covered. The fees charged for this procedure do not include any potential future costs for additional procedures that you elect to have or require in order to revise, optimize, or complete your outcome. Additional costs may occur should complications develop from the surgery. Secondary surgery or hospital day-surgery charges involved with revision surgery will also be your responsibility. In signing the consent for this surgery/procedure, you acknowledge that you have been informed about its risk and consequences and accept responsibility for the clinical decisions that were made along with the financial costs of all future treatments.

Payment Options:
You can choose from:

- Cash, Check, Visa, Mastercard, American Express or Discover Card
  We offer a 3% courtesy accounting adjustment to patients who pay for their treatment with cash prior to completion of care for treatment plans of $1500 or more.
- CareCredit Payment Plans

Patient Consent for Use of Credit Cards, Debit Card, and Financing - Disclosure of Protected Health Information:
It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment.

Services that are performed and are paid with a credit card, debit card, or financing third party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Dr. K Alex Kim to use and disclose my protected health information to any credit card entity, bank, or financing company when they request such information to process an account and assist with payment.

____ I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy.

____ I agree that this non credit card challenge agreement is irrevocable.

Please note:
Dr. Alex Kim requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For larger, more comprehensive treatment plans of $1000 or more, a $1000.00 deposit is required to secure your initial treatment appointment.

For patients with insurance we are happy to work with your carrier to maximize your benefit and provide you with the documentation you need to receive reimbursement for your treatment.

There is a $25 charge for any returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the quality care you want or need.

Signature ____ Date: ________________

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HEALTH INSURANCE

Most health insurance companies exclude coverage for cosmetic surgical operations or any resulting complications. Please carefully review your health insurance subscriber-information pamphlet. Most insurance plans exclude coverage for secondary or revisionary surgery due to complications of cosmetic surgery. It is unethical and fraudulent to bill insurance for cosmetic procedures. We cannot participate in such activities.

I hereby authorize **Dr. K. Alex Kim** to bill to the insurance company for the covered benefit on my behalf. I am personally responsible for all necessary co-payment, and deductibles. If the benefit is denied by the insurance company, I will be responsible for all the charges for the services provided.

Legal Assignment of Benefits and Designation of Authorized Representative

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Dr K Alex Kim, **as my designated Authorized Representative(s)**, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider to release all medical information necessary to process my claims under HIPAA.

I hereby authorize any plan administrator or fiduciary, insurers and my attorney to release to such provider any and all plan documents, insurance policy and/or settlement information upon written request from such provider in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named provider, to the full extent permissible under the law including but not limited to, ERISA section 502(a)(1)(B) and section 502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the named provider, and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies including, but not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

______________________________ ______________

Signature of Insured Guardian Date

____

Name of the patient

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MEDICAL PHOTOGRAPHY CONSENT

I hereby consent to the taking of medical photographs for use by Dr. K. Alex Kim during the course of my care and treatment.

Photographs are kept as part of my medical record and will be kept strictly confidential.

X ____ ______________________
Patient signature or parent if minor Date

CONSENT TO ACADEMIC AND COMMERCIAL USE OF PHOTOGRAPHS

I fully and specifically grant my permission for the use of photographs, videotapes or case information in all forms and media for purposes of advertising, trade, editorial usage, and any other lawful purposes, including but not limited to a website, social media site, office photographic book, brochures, other internet exposure, or other advertising items, for the following additional purposes as indicated by my initials below. As a result of this use I understand that these photographs, videotapes or case information may appear in other related, updated or reprinted formats at any concurrent or future occasion. I understand that such consent is strictly on a voluntary basis. I understand a copy of this consent may be supplied with the images to any third party wherein they may be published or presented. I understand that some photographs may, by their representation make me identifiable in appearance to others. We will take all reasonable precautions to ensure your privacy, but be aware that even secure sites are susceptible to being hacked, and the files, although they do not have your name attached, may contain internal codes the websites plan to “scrub” or delete. We will notify you if there has been a violation from these other sources, and we will protect your privacy to the best of our ability. I authorize K Alex Kim M.D. to use my photographs, videotapes, and case information in the following settings that I have initialed:

______ My surgeon’s office patient education materials
______ My surgeon’s file of pre- and postoperative patient photographs available to prospective patients for viewing in the office
______ Newspaper and magazine articles in which my surgeon participates
______ Television programs in which my surgeon participates
______ My surgeon’s professional web site, or social media pages
______ Lectures and multimedia presentations given by my surgeon for the general public

I also authorize my plastic surgeon’s professional association, the not-for-profit **American Society of Plastic Surgeons**, to use my photographs and case information in fulfilling its mission of public education, in the settings that I have initialed:

______ Patient education brochures available for purchase
______ Educational video tapes available for purchase
______ Lectures and slide presentations available for purchase
______ Television programs about plastic surgery

X ____ ______________________
Signature of Patient or Personal Representative Date

____ ____
Printed Name of Patient or Personal Representative Relationship of Personal Representative to the Patient

____
Signature of Practice Representative / Witness