ENDOCRINOLOGY

SANDRA S. KWAK, M.D., INC.

Dear Future Patient,

Please remember to bring the following items to your appointment:

1. Insurance card(s) – [No Exceptions – Patients will not be seen without Insurance Card(s)]
2. Photo ID (Government-issued – such as Driver's License or Identification Card). [No Exceptions – Patients will not be seen without a Photo ID]
3. All medications in the original containers **and** a list of medications (including dose and frequency)
4. Any other medical information you may have pertaining to your visit (labs, imaging studies, etc.)
5. Please make sure to call your referring physician (if applicable) and have their office fax over your medical records at least 2 days prior to your appointment and call us to verify receipt of the medical records
6. If you are a diabetic, please bring your glucometer to every visit
7. Please arrive to your appointment at least 30 minutes prior to your appointment so that you can be seen on time as scheduled.

- **Note: Your appointment time will start at your scheduled time. If you are late or do not have your paperwork filled out completely ahead of time, then you may be asked to reschedule your appointment.**
- **Co-Pays are due at the time of service (Cash or Credit Card ONLY for the initial visit)**
- **Please note that it is your responsibility to verify coverage for labs/imaging studies with your insurance plan. If you are in doubt whether certain labs or imaging procedures are covered, please call your insurance plan's member services department and verify. It is your responsibility to call your insurance plan and notify us if a Prior Authorization is necessary.**
- Please read the Privacy Practices prior to signing the Privacy Practices Acknowledgement of Receipt
- Directions can be found on our website: www.SandraKwakMD.com under "Contact Us".
- Please call us if you have any questions

520 SUPERIOR AVE., SUITE 310, NEWPORT BEACH, CA 92663
PHONE: (949) 645-8800 FAX: (949) 645-8844
WWW.SANDRAKWAKMD.COM

Sandra S. Kwak, M.D., Inc.
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520 Superior Ave., Suite 310
Newport Beach, CA 92663
Phone (949) 645-8800 Fax (949) 645-8844
Website: www.SandraKwakMD.com

Date

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed _____ Other

Name: (Last Name) , (First Name) (Middle Initial) Social Security # Age Date of Birth

Sex: ☐ Male ☐Female

Address: (Street) (City) (State) (Zip Code)

Home Phone Cell Phone Email Address

☐ By checking this box, I give permission to Dr. Sandra Kwak and her staff to leave detailed messages on my cell phone regarding my medical condition and lab/imaging results. Initial _____

☐ By checking this box, I give permission to Dr. Sandra Kwak and her staff to leave detailed messages on my home phone regarding my medical condition and lab/imaging results. Initial _____

☐ I give permission to the following people, named below, to speak on my behalf, with the physician, her staff, her billing service and insurance companies. Initial _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ I am aware that Dr. Sandra Kwak does not provide primary care services and can provide referrals to a primary care physician upon my request.
Initial

Occupation Employer Work Phone

Referring Physician Referring Physician's Phone # Referring Physician's Fax #

Primary Care Physician Primary Care Physician's Phone # Primary Care Physician's Fax #

ALLERGIES: _____

REASON FOR ENDOCRINE CONSULTATION:

1. _____
2. _____
3. _____

PAST MEDICAL HISTORY:

Medical Problems:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Patient's Name: _____

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Date: _____

Surgeries: _____
(Date, Type, Hospital, Complications) _____

Hospitalizations: _____
(Date, Reason, Hospital) _____

Medication Name	Dose	How many pills how often ?	Comments: (Medication Start Date)

Do you have any of the following conditions ?

____ Diabetes
____ High Blood Pressure
____ High Cholesterol
____ Heart Disease
____ Breast Cancer
____ Thyroid Disease
____ Radiation Exposure
____ Autoimmune Disease
____ Prostate Problems
____ Kidney Stones
____ Liver Disease
____ Kidney Disease
____ Eye Disease
____ Neuropathy
____ Vascular Disease
____ Osteoporosis
____ Lung Disease
____ Asthma
____ Menstrual Problems
____ Anemia
____ History of Head Trauma
____ Other (specify below)

_____

FAMILY HISTORY: Are you adopted ? ☐ Yes ☐ No

Do any of your blood relatives have the following conditions ? If so, which family member ?

____ Diabetes
____ High Blood Pressure
____ High Cholesterol
____ Thyroid Disease
____ Heart Disease
____ Kidney Disease
____ Breast Cancer
____ Cancer (specify) _____
____ Autoimmune Disease
____ Other Conditions (specify) _____

SOCIAL HISTORY:

Do you smoke ?_____ If so, how many/day ?_____ For how long?_____ In the past ?_____

Do you drink alcohol ?_____ If so, how often ? _____ Do you regularly drink one or more drinks per day ? ☐ Yes ☐ No

Do you use drugs socially ?_____ If so, what type and how often ? _____

Do you exercise regularly ?_____ How many times a week ? _____ For how many minutes ?_____

Type of Exercise: _____ Diet Description: _____

Patient's Name: _____

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Date: _____

REVIEW OF SYSTEMS:

Do you have the following problems ?

	Yes	No
Fatigue		
Weight Gain		
Weight Loss		
Hair Loss		
Unwanted Hair Growth		
Excessive Sweating		
Dry Skin		
Brittle Nails		
Skin Paleness		
Skin Darkening		
Rash		
Acne		
Feet Ulcers		
Purple Stretch Marks		
Neck Pain (Thyroid Area)		
Increase In Neck Size		
Voice Hoarseness		
Headache		
Head Injury		
Peripheral Vision Problems		
Vision Changes		
Difficulty Breathing		
Shortness Of Breath (With Exertion)		
Cough		
Swelling Of Extremities		
Palpitations		
Rapid Heart Rate		
Irregular Heart Beat		
Murmur		
Chest Pain		

	Yes	No
Difficulty Swallowing		
Nausea		
Vomiting		
Diarrhea		
Constipation		
Abdominal Pain		
Acid Reflux		
Muscle Cramps/Pain		
Joint Pain		
Muscle Weakness		
Numbness		
Tingling		
Tremor		
Dizziness		
Loss Of Consciousness		
Depression		
Anxiety		
Insomnia		
Excessive Sleeping		
Inability To Concentrate		
Excessive Thirst		
Excessive Urination		
Cold Intolerance		
Heat Intolerance		
Hot Flashes		
Swollen Glands		
Easy Bruising		
Unexplained Bruising		
Anemia		
Blood Transfusions		

	Yes	No
Nipple Discharge		
Recent Breast Changes		
Sexual Dysfunction		
Urination Problems		
Genitalia Changes		
Menstrual Irregularities		

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Patient Information: Last Name:_____ First:_____ Middle:_____

Date of Birth:_____ Age: _____ Social Security # _____

Address:_____ City:_____ Zip Code: _____

Home Phone #:_____ Cell Phone #:_____ E-mail:_____

Drivers License #: _____ Circle: Male / Female Marital Status: M / D / S / W

Referred By:_____NPI (Office Use Only)_____

Employment Information:

Occupation: _____ Employed by: _____

Address:_____ City:_____ Zip Code: _____

Work Telephone #:_____

Emergency Contact Information:

Name:_____ Relationship:_____

Address:_____ City:_____ Zip Code: _____

Telephone #: _____

Insurance Carrier: _____ ID #:_____ Group#:_____

Language: ☐ **English** ☐ **Other:** _____

Ethnicity: ☐ **Refused to Report/Unreported** ☐ **Hispanic or Latino** ☐ **Non-Hispanic or Latino**

Race: ☐ **Refused to Report/Unreported** ☐ **More than one race** ☐ **African Indian/Alaska Native** ☐ **Asian**
☐ **Black or African American** ☐ **Native Hawaiian** ☐ **White** ☐ **Other Pacific Islander**

ALLERGIES:_____

Assignment of Benefits/Financial Agreement:
I hereby give authorization for payment of insurance benefits to be made directly to Sandra S. Kwak, M.D., Inc. for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance company (Medicare patients are subject to Medicare's policies and regulations). I hereby authorize this healthcare provider to release all information necessary to my insurance company(s) to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature:_____ Date:_____

Sandra S. Kwak, M.D., Inc.

Patient Acceptance of Financial Responsibility

The practice of Sandra S. Kwak, M.D., Inc. will bill your insurance company as a courtesy. However, you are ultimately responsible for all charges for services rendered. In the event services rendered are not covered by your insurance company we will require that you remit payment to Sandra S. Kwak, M.D., Inc. Additionally, if your insurance company does not remit payment in a timely manner (within 60 days from the time your claim is billed), we will transfer the balance to your responsibility and require that you remit payment to Sandra S. Kwak, M.D., Inc. for all outstanding balances over 60 days. The outstanding balances may include, but are not limited to:

- Office visit co-payments
- Annual deductibles
- Services that are not covered by your health plan
- Administrative charges for co-pays not paid at the time of service
- Interest charges for overdue patient due balances

In addition, your insurance company may require authorization or pre-certification for certain procedures, services drugs and supplies that will be provided to you. It is ultimately your responsibility to understand what your insurance policy covers and assure that you have authorization for services. Your assistance in contacting your insurance company will often facilitate a more timely approval of services, prevent delays in treatment, and expedite payment for your services.

We frequently experience difficulty with insurance plans in receiving timely payment. Our policy is that we will bill your insurance policy. If we do not receive payment within 60 days of the date we billed your insurance then we will transfer the balance to your responsibility and require that you remit payment to Sandra S. Kwak, M.D., Inc. To prevent this, we suggest that you stay in communication with your insurance company to assure they are paying for the services we render. Often, insurance companies are more responsive when they are contacted by their policyholders. In addition, your prompt response to calls from our billing office will assist in obtaining timely payment from your insurance company. The billing office may be reached at 866-853-0847 and they are available to assist you in obtaining payment on your claims.

We require timely payment when you receive your statement. Balances are due upon receipt of your statement. Your co-payment is required at the time you check-in for your appointment (before services are rendered).

All patient balances that are past due (greater than 30 days) will accrue an interest charge of $15 for each month of your outstanding balance. Additionally, patient balances must be paid in full prior to any subsequent visits or will be collected prior to the rendering of any subsequent services.

***Any checks returned to us as Non-Sufficient Funds will incur a fee of $25.00.**

I (or the person named below who is financially responsible for me) understand and agree that I (or the person named below who is financially responsible for me) am financially liable for all services rendered and will pay my outstanding balance within 10 days of receipt of my statement. I (or the person named below who is financially responsible for me) understand that if my insurance plan does not pay Sandra S. Kwak, M.D., Inc. within 60 days of services billed, the balance will be transferred to my responsibility and payment will be due at that time.

_____	_____
Patient Printed Name	Responsible Party's Printed Name
_____	_____
Patient's Signature	Responsible Party's Signature
_____	_____
Date	Date

NOTICE OF PRIVACY PRACTICES:
Acknowledgement of Receipt

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices*** of:
Sandra S. Kwak, M.D.

Our ***Notice of Privacy Practices*** provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our ***Notice of Privacy Practices*** is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Privacy Officer at (949) 645-8800.

I acknowledge receipt of the ***Notice of Privacy Practices*** of:
Sandra S. Kwak, M.D.

Signature: _____ Date: _____
(parent/patient/conservator/guardian)

I_____ authorize Sandra S. Kwak, M.D. to access my medical records.
(Print Patient Name)

FOR OFFICE USE ONLY

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained:

Signature of provider representative: _____ Date: _____

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please Specify)