KALLAL MEDICAL GROUP

Insurance Information

First Name	**Middle Initial**	**Last Name**	**"Preferred Name"**
Social Security Number	**Date of Birth**	**Drivers License Number**	**Sex (Check One)** □ Male □ Female
Address	**City**	**State**	**Zip**
Marital Status (Check One) □ Single □ Married □ Divorced □ Widowed	**E-mail Address**		
How were you referred to our office? _____			
Primary Phone	**Secondary Phone**		
Emergency Contact (Please list someone not living with you)	**Relationship**	**Phone Number**	
Spouse Name (If Applicable)	**Phone Number**		
Employer Name	**Employer Address**		
Preferred Contact Method ◘ Home Phone ◘ Cell Phone	**May we contact you at work?** ◘ **Yes** ◘ **No**		

Primary Insurance	**Effective Date**		**Secondary Insurance**	**Effective Date**	
Claims Mailing Address (Street or Box)			**Claims Mailing Address (Street or Box)**		
City	**State**	**Zip**	**City**	**State**	**Zip**
Policy Number	**Group Number**		**Policy Number**	**Group Number**	
Policy Holder Name	**Date of Birth**		**Policy Holder Name**	**Date of Birth**	
Social Security Number	**Relationship to Patient**		**Social Security Number**	**Relationship to Patient**	

I hereby certify that the information given above is true and correct to the best of my knowledge.

Patient Signature (or Legal Guardian) _____ Date _____

KALLAL MEDICAL GROUP

INSURANCE COVERAGE AGREEMENT

Your Insurance Coverage: Is an agreement between you and your insurance company. We agree to file the claim for you and accept the contracted payment.

It is your responsibility to remit payment for deductibles, co-pays, and charges not covered by the plan.

In order for this office to process your claim, it is important that you present your insurance card at each visit. The card must match the patient being seen.

If a problem occurs with your claim, coverage is terminated or denied it is your responsibility to contact your insurance and insure payment or initiate a payment plan with our practice until your insurance problem is resolved. Past due accounts are subject to credit processing.

Consent to treatment: I hereby grant permission to the physician in charge of my case and such assistants as he or they may designate, to perform and administer all treatments and diagnosis, which in their fair judgment may be considered necessary or advisable for the patient's well being.

Release of information: I hereby authorize Dr. Kevin Kallal or associates in charge of my care to release information contained in my medical records to the insurance company or companies, agents or independent contracts thereof, for the purpose of processing my claims for insurance benefits.

Financial agreement: The undersigned hereby agrees that in consideration for services rendered, payment of the account is guaranteed in accordance to the regular rates and terms of Dr. Kevin Kallal. The undersigned clearly understands that payment obligation is the responsibility of the patient and or undersigned.

Assignment of benefits: I hereby assign to Dr. Kevin Kallal or associates associated with my care and treatment any interest and/or benefits provided under my insurance policy or policies. I also understand that any balance not covered by insurance is due and payable by me.

_____ _____

Patient or Representative/Relation Date

_____ _____

Witness Date

KALLAL MEDICAL GROUP

Protected Health Information Disclosure Authorization

We are legally obligated to maintain the privacy of your protected health information and to abide by the terms of this agreement. We will provide you the opportunity to review the Notice Of Privacy Practices and ask any questions you may have. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

I authorize Kallal Medical Group to communicate my protected health information (PHI) in the manner indicated below.

(Check All That Apply)

☐ Primary # ☐ Secondary # ☐ U.S. Mail

☐ Leave a detailed message on my on my answering/voicemail.

☐ Leave a brief message with only a call back number on my answering machine/voicemail.

Persons authorized to discuss medical information:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with the Office Manager or Privacy Officer to obtain additional information regarding any questions you may have regarding this Notice or to receive a printed copy of this Notice. This Notice of Privacy Practices if effective April 14, 2003.

Patient Name (*Please Print)* _____ Date _____

Patient Signature _____ Date _____
(Or Legal Guardian)

KALLAL MEDICAL GROUP

NOTICE OF PRIVACY PRACTICES

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.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction, you have the right to receive confidential communications of your protected health information, you have the right to inspect, copy, and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with the Office Manager or Privacy Officer to obtain additional information regarding any questions you may have regarding this Notice or to receive a printed copy of this Notice. This Notice of Privacy Practices if effective April 14, 2003.

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PAST MEDICAL HISTORY

Name: _____ Date: _____

If checked you, please indicate year of diagnosis:

☐ Diabetes	_____	☐ Asthma	_____	☐ Sinusitis	_____
☐ Coronary Disease	_____	☐ Kidney Disease	_____	☐ Allergies	_____
☐ High Blood Pressure	_____	☐ Colon Cancer	_____	☐ Thyroid Disease	_____
☐ Stroke	_____	☐ Breast Cancer	_____	☐ Migraine	_____
☐ High Cholesterol	_____	☐ Acid Reflux	_____	☐ Glaucoma	_____
☐ Lung Disease	_____	☐ Hiatal Hernia	_____	☐ Depression	_____

Surgical History

☐ Gall Bladder	_____
☐ Hysterectomy	_____
☐ C-Section	_____
☐ Heart Surgery	_____
☐ Cancer Surgery	_____
☐ Appendix	_____
☐ Tonsillectomy	_____

Immunizations

☐ Tetanus	_____
☐ Pneumovax	_____
☐ Hep B	_____
☐ Hep A	_____
☐ Influenza	_____
☐ Other	_____

_____

Major Injuries

Type	Date

Social History

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed

Alcohol: Number per _____ Day _____ Week _____ Month

Tobacco: ○ None ○ Past ○ Current Type _____ Amount _____ Years _____

Street Drugs: _____ _____ _____ _____

Seat Belt: ○ Always ○ Seldom ○ Never

Occupation

Occupation Risks: ☐ Noise ☐ Fumes ☐ Back Strain

KALLAL MEDICAL GROUP

FAMILY HISTORY

If checked, please list relationship:

☐ High Blood Pressure	_____	☐ Diabetes	_____	☐ Drug Abuse	_____
☐ Stroke	_____	☐ Colon Cancer	_____	☐ Domestic Violence	_____
☐ Heart Attack	_____	☐ Breast Cancer	_____	☐ Child Abuse	_____
☐ High Cholesterol	_____	☐ Other Cancer	_____	☐ Hereditary Disorders	_____
☐ Coronary Disease	_____	☐ Alcoholism	_____	☐ Mental Illness	_____

	Age	Current Health	Age at Death	Cause of Death
Father				
Mother				
Brother				
Brother				
Sister				
Sister				

ARE YOU ALLERGIC TO ANY MEDICATIONS? ○ Yes ○ No

(If yes, please list medications)

_____

_____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? ○ Yes ○ No

(If yes, please list medications, including herbal)

_____

_____

UPLOAD **completed form to Kallal Medical Group via secure website form.**