DR. KUSUM T. NIGAM INTERNAL MEDICINE, PLLC

4402 Churchman Ave, Suite 410
Louisville, KY 40215
Phone (502) 367-6322, Fax (502) 380-3843

Patient Information Sheet

Name _____SSN _____DOB _____

Address _____City_____State_____ZIP_____

Home Phone _____Cell # _____Your Email_____

Would you like access to your online Patient Portal Account? _____

Race _____ Ethnicity- Non-Hispanic _____Hispanic_____Language _____

Marital Status- Married_____ Single_____ Divorced_____ Widowed_____

Pharmacy Name& Address _____Phone _____

Employer Name _____ Address _____Phone_____

Emergency Contact _____ Phone # _____Relation_____

Please write YES or NO if you grant your emergency contact access to your protected health information_____

Insurance Information

Primary Insurance

Name _____ID#_____Group #_____

Secondary Insurance

Name _____ID#_____Group#_____

Permission for treatment is hereby granted to Dr. Kusum T. Nigam Internal Medicine, PPLC to render such medical and surgical treatment as deemed necessary.

Authorization for Dr. Kusum T Nigam Internal Medicine, PLLC to release medical information to the extent necessary to determine insurance benefits, liability for payment and to obtain reimbursement. The patient's medical information may also be used to the referring physician to ensure continuity of medical care.

I understand this practice may file an assigned claim to insurance carrier on my behalf, **but I fully understand it is my responsibility to contact my insurance carrier(s) if payment has not been received within 30 days.** I understand it is my responsibility to give the practice updated information should my information change in any way. **All co-payment and balances are to be paid before being seen by the physician.**

I hereby authorize payment of benefits related to services provided by Dr. Kusum T Nigam Internal Medicine, PLLC to be paid directly to the physician. **Please give your insurance cards to the receptionist to be copied.**

Patient or GuardianSignature _____ Date _____

Updated 08/05/2019

HEALTH HISTORY

Name: _____ Date of Birth: _____Date: _____

Do you see other physicians? Y/N If yes, please list name, specialty and phone#: _____

_____

Please list all allergies you may have to medications, foods, chemicals, etc. : _____

_____Latex Allergy? Y/N

Please list any surgeries and/or hospitalizations you have had, and the year:_____

_____

FAMILY MEDICAL HISTORY (Circle illnesses in blood relatives)

TB Bleeding Tendency Kidney Disease Heart Disease Mental Illness

Diabetes Cancer Stroke High Blood Pressure Other

PERSONAL MEDICAL HISTORY (Circle illnesses that apply to you)

HIV/AIDS	Chemical dependency	Glaucoma	Pacemaker
Asthma	Chronic bronchitis	Gall stones	Pneumonia
Angina	Cirrhosis	Heart disease	Polio
Anemia	Colitis	Hepatitis	Prostate Prob
Arthritis	Chicken pox	High blood pressure	Stroke
Blood transfusions	Depression	High cholesterol	STD
Bleeding disorder	Diabetes	Heart murmur	Thyroid Prob
Breast lump	Emphysema	Kidney disease	TB
Cancer	Epilepsy	Liver disease	Ulcers
Cataracts	Fracture	Migraine/Headaches	Other

PREVENTION/SCREENING	DATE	IMMUNIZATION	DATE
Pap smear		Pneumonia	
Mammogram		Flu	
Colonoscopy		Tetanus (TD)	
Cholesterol		Hepatitis	
PSA		TB skin test	

HEALTH HABITS

YES	NO	
_____	_____	Have you used tobacco? At what age did you start? _____ Packs per day?____
_____	_____	If you consume caffeine (i.e. coffee, tea, soda), how much per day? _____
_____	_____	Do you drink any alcohol? If yes, how much per day? _____
_____	_____	If you exercise- Days per week: _____Hours per day_____Type_____

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Financial Policy

To help provide the most efficient and reasonable health care services, it is necessary for us to have Financial Policy stating our requirements for payment of our services provided to our patients.

Patients are responsible for payment of all services provided by our office. It is our policy to file for insurance as a courtesy to you if we have accurate and complete information. The balance due is still your responsibility if we have not received payment form the insurance company within 30 days. Also, please be aware that your blood work is sent to an outside laboratory and your insurance information is forwarded to this lab. You may have some out of pocket expenses from this laboratory; please contact the lab with any questions.

If you have insurance and we file with your carrier, we require payment of the balances which are deemed your responsibility (co-payment, deductibles, and co-insurance) at the time the service is received. We ask that you please contact your insurance company if you claim has not been paid within 30 days.

If you do not have insurance, and are not covered by Medicare or Medicaid, you will be considered a "Self Pay" patient. Payment is due at the time of service.

We do offer a cash pay only Weight Loss Program. We do not file with any insurance for this program.

Our office does accept cash for payments. Additionally, as a convenience to you, we do accept Visa and Mastercard for payments. **Please note that a $2.00 convenience fee will be applied, per transaction, for all forms of card payments.**

If at any time we accept a check from you and it is returned, you must pay the amount of the check and a returned check fee before you can be seen again.

If you find that you cannot keep your appointment, please call the office within 24 hours to notify us and to avoid being charged a "No-Show" fee. <u>If you are a "No-Show" you will be charged a $25.00 fee that you will be required to pay before you can be seen again.</u> After 3 consecutive "No Shows", we reserve the right to dismiss you from our practice.

In addition, we will update your information at least once a year or upon any changes in address, phone number or insurance. Please understand this is to help us keep up to date on all your information and to file your insurance correctly.

Patient or Guardian Signature _____ **Date** _____

Patient Name (Printed) _____**Date of Birth** _____

Updated 08/05/2019

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PRIVACY PRACTICES

Please Complete Only One Section Below:

I, _____, refused a copy of Dr.Kusum T. Nigam Internal Medicine's Notice of Privacy Practices.

Signature _____ DOB_____ Date _____

If not signed by patient, please indicate Relationship:

_____ Parent or guardian of minor patient
_____ Guardian or conservator of an adult
_____ Beneficiary or personal representative

I, _____, would like a copy of this practice's Notice of Privacy Practices.

I would like to receive a copy of the Notice of Privacy Practices by: Mail_____In Office_____

Signature _____DOB_____ Date _____

If not signed by patient, please indicate Relationship:

_____ Parent or guardian of minor patient
_____ Guardian or conservator of an adult
_____ Beneficiary or personal representative of a deceased patient
_____ Other (please specify) _____

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CONFIDENTIAL CHANNEL COMMUNICATION REQUEST

As required by the Health Insurance Portability and Accountability Act (HIPPA) of 1996 you have the right to request that communication concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will try to accommodate all reasonable requests.

I, _____, hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. This request supersedes any prior request for confidential channel communications I may have made.

Please select all that may apply.

PHONE:I would like to be contacted at the following phone numbers:

HOME _____ May we leave a voicemail at this number?_____

CELL _____ May we leave a voicemail at this number?_____

OTHER _____ May we leave a voicemail at this number?_____

If you would like for us to be able to leave a message with someone, please write their name, date of birth and address below.

A message will only be left with the named person (s):

1. Name_____DOB_____Relationship_____

2. Name_____DOB_____Relationship_____

3. Name_____DOB_____Relationship_____

MAIL:I would like to be contacted at this address: _____

_____

FAX: If necessary, please fax information via this number: _____

If there is another method by which you would like to be contacted, please list it here:

_____

Patient or Guardian Signature_____ Date_____

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LIVING WILLINFORMATION

It is our goal to have a copy of a living will or an Advanced Directive on a chart if the patient has had one filled out. Please answer the question below as to whether or not you have a Living Will or Advanced Directive.

It is NOT our goal to try to get a patient to fill out a Living Will or an Advanced Directive or to convince the patient one way or another in this decision.

Does patient have a Living Will or an Advanced Directive? Yes_____ No _____

If so, is there a copy in the chart? Yes _____ N/A _____

Patient Signature_____

Print Name _____

Date of Birth _____ Date Signed _____

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GENERAL CONSENT FOR TREATMENT, EVALUATION, AND INFORMATION RELEASE

Patient Name: _____ Date of Birth: _____

By signing below, I voluntarily agree to the following provisions of this form:

CONSENT TO TREATMENT

I allow *DR KUSUM T NIGAM INTERNAL MEDICINE, PLLC* to provide health care services to me that may be deemed to be routine or otherwise necessary. I consent to evaluation or treatment that the assigned healthcare provider may deem necessary. This may include diagnostic, radiology and laboratory procedures, and medication administration. I understand that I have the right to refuse consent to any proposed procedure or treatment at any time prior to its performance.

GENERAL RELEASE OF INFORMATION

I acknowledge that I have received a copy of the Practice's Notice of Patient Privacy Practices, which describes the permitted uses and disclosures of my protected health information related to my care by the Practice, and payment of my charges for the services received at the Practice. I specifically authorize the uses and disclosures of my health information described in the Practice's Notice of Patient Privacy Practices.

I consent to release of my health information, including but not limited to psychiatric, substance abuse, communicable disease, genetic testing, venereal disease, and HIV information (referred to in this form as "Sensitive Conditions"), for medical purposes and for payment purposes to third parties including but not limited to federal or state health plans, insurance companies , collection agencies, employers or other organizations responsible for payment of my charges for the services received at the Practice. I also consent to release of this information for the Practice's day-to-day health care operational purposes. I understand that my health information may include information relating to my health condition, care, or payment for my care, including telephone numbers and other demographic information.

HEALTH INFORMATION EXCHANGE. Health information exchange allows health care providers to share health care information about patients electronically for several purposes, such as treatment, quality assurance and state law reporting requirements. I understand that if I go to the Practice for treatment, the physicians and/or their staff may get a copy of my medication history and other health care information electronically through various health information exchange connections with other health care providers.

I understand I may request that my health care information not be shared through electronic health information exchange by following the directions in the Practice's Notice of Patient Privacy Practices.

BY SIGNING BELOW, I AM AGREEING TO THE CONSENTS AND RELEASES DESCRIBED ON THIS FORM. I HAVE READ THIS CONSENT AND HAVE BEEN ABLE TO ASK QUESTIONS.

_____	_____	_____
Printed Name of Patient	Signature of Patient	Date
_____	_____	_____
Legal Representative Printed Name	Legal Representative Signature	Date

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AUTHORIZATION FOR THE USE AND/ORDISCLOSURE OF PROTECTED HEALTH INFORMATION

WE HEREBY REQUEST A RELEASE OF THE FOLLOWING PATIENT'S MEDICAL RECORD:

***Patient Name:** _____

***DOB:** _____ ***SSN:** _____

The following individual or organization is authorized to make the disclosure

Doctor/Facility:_____Phone #: _____

Address: _____

I authorize the use and/or disclosure of my protected health information as follows:

My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization.

_____ Entire Medical Record _____Lab(s) and Test(s) done on _____

_____ Records for the following dates only: _____

The authorization includes release of information concerning treatment, psychiatric/psychological conditions, drug and/or alcohol related conditions, and HIV or AIDs related conditions.

The above information is to be released to DR KUSUM T. NIGAM INTERNAL MEDICINE, PLLC.

THE ABOVE INFORMATION IS REQUESTED TO BE RELEASED FOR THE FOLLOWING PURPOSE:

_____Continued Medical Care _____Other_____

This authorization must be signed and dated, and may be revoked at any time, except to the extent that information has already been used or disclosed. The Authorization of Revocation must be made in writing to the Releaser of the information. This information will expire three-hundred and sixty five (365) days from the date of this form or on the following event _____. Thus hereby acknowledge that I understand treatment, payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing of this Authorization. Once these records are released, the information is not protected under HIPAA, and may potentially be re-disclosed by the party who received these records. I hereby state that I have read and fully understand the above statement they apply to me.

***Patient Signature:** _____ ***Date:** _____

Patient Guardian/ _____ Witness _____

Authorized Representative

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Controlled Substance Agreement

Controlled substances have the potential to be addictive and must be taken exactly as prescribed.

I, _____, understand that if I am prescribed a controlled substance I must adhere to the following restrictions. Failure to conform to any of the below listed restrictions may result in being dismissed from Dr. Kusum T Nigam Internal Medicine, PLLCand may result in being reported to the Louisville Metro Police Drug Squad.

Please INITIALeach of the following:

1. _____ I will not use any alcohol or illegal drugs while being prescribed medications.

2. _____ I will not take other prescribed medications without first notifying Dr. Nigam.

3. _____ I will notify Dr. Nigam immediately of any other physician(s) currently prescribing me a controlled substance(s) or that have been prescribed to me in the past thirty (30) days, including Emergency Rooms and Immediate Care Centers. Failure to do so is a FELONY CRIME and may be reported to the Louisville Metro Police Drug Squad.

4. _____ I will submit to random urine, oral, and/or serum drug screens as ordered.

5. _____ I will purchase all of my medications at the same pharmacy and I authorize Dr. Nigam to communicate with my pharmacist. My chosen pharmacy is _____, which is located at _____, their phone # is _____.

6. _____ I understand that it is illegal to share my medication(s). If I am found to be sharing my medication(s), I understand that I may be discharged from Dr. Kusum Nigam Internal Medicine, PLLC.

7. _____ I agree to keep my medication locked in order to prevent loss or theft. I agree not to keep medication in my purse or pockets.

8. _____ I understand that I will be taken off this medication if there is evidence of addition or abuse.

9. _____I understand that some medication may cause drowsiness and slower reflexes, interfering with the ability to drive and operate machinery, and may cause short-term memory impairment.

10. _____I agree to keep all scheduled appointments at Dr. Kusum Nigam Internal Medicine, PLLC. My medication may be weaned and discontinued if I fail to attend my scheduled appointments.

11. _____I also understand that part of my treatment may involve reduction and discontinuation of any addictive medications.

12. _____I authorize this office to release a copy (or original) of this controlled substance agreement to the Louisville Metro Police Department Prescription Drug Squad if I violate any of the listed terms or at their request.

13. _____I understand that I may be called to the office for a count of all my remaining medication(s) at any time.

14. _____I waive my right of privacy and authorize Dr. Nigam to contact any healthcare provider, legal authority, friend and/or relative in order to obtain information about my care, including abuse of controlled substances, legal or otherwise.

15. _____I also understand that per Dr. Kusum T Nigam Internal Medicine's Office Policy, I must **schedule** and**attend** an appointment in that office for ALL my controlled substance refills.

No refillswill be given on weekends, holidays, after hours, or by producing a police report.

Lost, stolen, spilled, and/or wasted medications will not be replaced.

Please list ALL prescription medications from any other physician within the last thirty (30) days**. Please list medication and prescribing physician.**

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Patient Signature_____ Date_____

Print Patient Name_____