# Kumar Quality Medical Care New Patient Questionnaire

Name ____________________________________________ Date___________

Chart Number (office use) ____________

1. Do you use tobacco products?__________What kind?________________How many?______________________
   If you smoked in the past, when did you quit?__________________________________________________

2. Do you drink alcoholic beverages?_________________
   If so, which ones and how much per day?_______________________ and week______________________?

3. Have you participated in recreational drugs within the last year? ______________________

4. **Date of last Immunizations:**

   Tetanus_______________ Influenza (flu)____________ Covid-19________________

   Shingles______________ Hep A__________________ Hep B___________________

   Pneumonia (Pneumovax or Prevnar 13)______________________

5. **Date of Screenings:**

   Cholesterol ______________ Eye Exam ________________ Colonoscopy______________

   Dental Exam_____________ Prostate Test ( ***men only***)___________________

   ***Women Only***: Bone Density Test___________ Pap Smear____________ Mammogram__________

   Date of last period___________

| 6. **Past Medical Hospitalizations:** | | **Past Surgery:** | |
|---|---|---|---|
| Date | Reason | Date | Reason |
| | | | |
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7. Current Medications (Include prescribed medications, over-the-counter, vitamins, sleep aids, laxatives etc.)

| MEDICATION | DOSE | FREQUENCY TAKEN | MEDICATION | DOSE | FREQUENCY TAKEN |
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8. Are you allergic to any medications? Please list them and what type of allergic reaction it causes.

| Medication | Reaction |
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9. Family History: Please check if a blood related member of your family has had any of the following:
☐TB ☐Heart Disease ☐Bleeding Tendency ☐Rheumatic Fever ☐High Blood Pressure ☐Anemia
☐Diabetes ☐Strokes ☐Arthritis ☐Thyroid Disease ☐Lung Disease ☐Mental Disease ☐Cancer
☐Kidney Disease ☐Glaucoma other disease:______________________________________________________

| Relative | Age(if living) | Age at Death (if deceased) | State of Health If not good, state reasons | Cause of Death |
|---|---|---|---|---|
| Mother | | | | |
| Father | | | | |
| Brother(s)<br>No. Alive___<br>Dead___ | | | | |
| Sister (s)<br>No. Alive___<br>Dead___ | | | | |
| Children<br>No. Alive___<br>Dead___ | | | | |

10. Other things about your health you wish the doctor to know: ______________________________________________

11. List any chronic diseases you have:____________________________________________________________________

_____________________________________________________________________________________________________

Signature of Patient or Guardian:__________________________________________ Date _______________

# Kumar Quality Medical Care Clinic Office Policies

Thank you for choosing Kumar Quality Medical Care for your healthcare needs. We strive to provide the quality service to our patients. To make your visit as pleasant as possible and prevent future misunderstandings regarding appointments and billing, please read and familiarize yourself with the following policies and procedures.

- Termination of the physician-patient relationship can occur at the request of the patient or the physician when the relationship is no longer proceeding in a mutually productive manner. If you are dismissed from the practice, emergency care only will be provided for 30 days to allow appropriate time to find further providers. Circumstances that may result in dismissal from the practice include:
  - Noncompliance with treatment
  - Failure to keep appointments
  - Threatening, demanding or abusive behavior directed toward our staff, physicians, other healthcare providers or patients
  - Deceptive behavior
  - Medication abuse
  - The patient leaves the practice
  - Failure to pay consistent with policy listed below
- If you require hospitalization, there is an agreement between the hospitalist group with Norton Community hospital at Norton, VA to provide quality care and communicate that care to your provider.
- We participate with most major insurance plans. If you are unsure whether your insurance is one we participate in, please call the member services for your insurance carrier.
- Please be aware that you are responsible for any portion of your bill that is not paid by your insurance company.
- We are obligated by contract to collect co-pays at the time of service, if you do not have your co-pay at time of appointment, services cannot be rendered except in the case of an emergency
- Insurance claims and appeals will be filed in a reasonable time frame and followed up on however if you are experiencing delays or difficulties with your insurance company in the payment of benefits, it is your responsibility to ensure your insurer abides by the plan you have.
- Patients will be responsible for any unpaid balance and notified of the balance monthly. At the end of 90 days unpaid balances will be turned over to a collection agency and the patient will be responsible for agency fees. Failure to remit payment on a past due account will result in dismissal from the practice.
- All returned checks are subjected to a fee of $25.
- If you are un-insured payment is due at time of service.
- If you have a significant balance and do not make arrangements to pay the balance, we will be unable to provide care until arrangements are made to pay the balance.

**I have read and understand the above policies, procedures and financial responsibilities, and agree to abide by this policy in exchange for quality medical care.**

__________________________________________________
Patient's Name (Print)

__________________________________________________ __________
Signature of Patient or Legal Guardian Date

# KQMC Medical Release Form

Patient Name______________________________________________ Patient Date of Birth__________________

Address___________________________________________________ Telephone Number____________________

___________________________________________________

I hereby authorize employees, medical staff member or other agents of Kumar Quality Medical Care to use or disclose the following protected health information:

☐ Copy of Complete Record (s) ☐ Lab Reports ☐ History/Physical Exam

☐ Progress Notes ☐ Discharge Summary ☐ Radiology Report/ Films

☐ Operative Report ☐ Pathology Reports ☐ Emergency Dept. Record (s)

Other_________________________________________________________________________________

○ Include: ○ Exclude:

My health information related to psychiatric or psychological conditions or treatment, except psychotherapy notes; alcohol and drug abuse; sickle cell anemia; and acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV).

To be used by or released to: Kumar Quality Medical Care, 610 Park Avenue NW, Norton, VA 24273

From the following healthcare provider (s):

Name:______________________________________________ Phone #___________________Fax #______________________
(Previous Primary Care)

Name:______________________________________________ Phone #___________________Fax #______________________

Name:______________________________________________ Phone #___________________Fax #______________________

For the following purpose: ☐ At the request of the patient ☐ Other____________________________________

Unless otherwise specified the Authorization will expire 6 months from the following date _________________________

**Authorization and Signature:** I authorize the release of my confidential protected health information, as described in my directions above. I have had the opportunity to read and consider the contents of this authorization. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. I further understand that refusing to sign this authorization will not affect my treatment, payment, enrollment, or eligibility for benefits. I understand that I may revoke this authorization in writing, except for any actions already taken based upon it. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by federal or state laws that limit the use and/or disclosure of my confidential protected health information.

Patient's Signature_______________________________________ Date________________________

The above individual is unable to consent because: ____Minor ___incompetent ___Other (explain)______________

Signature________________________________ Date_________________ Relationship______________________________

# New Patient Information

**Registration Information**

Patient Name__________________________________________ Date of Birth_________________ Gender__________

Social Security Number___________________________ Home #____________________ Cell #_______________________

Address: ________________________________________ City_______________________ State_______ Zip_____________

Previous Provider________________________________________ Preferred Pharmacy______________________________

**Patient Portal Services:** We are excited to announce that we have started using patient portal for you to look at your test results and view your upcoming appointments. If you wish to opt in, please list your email address below.

Email Address:_________________________________________________

**Medication Refills:** When you need a refill on your medication, please contact your pharmacy to send us a request. If it is regular medicine, we will refill once received. If it is a controlled substance, please allow 72 hours for pick up.

**Use of Disclosure of Health Information for Treatment, Payment, or Healthcare Operations**

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations, test-results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party pay can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

**Acknowledgment of Notice of Private Practices**

I understand that I have been provided the Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the Notice prior to signing this acknowledgment. I understand that KQMC reserves the right to change Notice and Practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that KQMC is not required to agree to the restrictions requested. I understand that I may revoke an authorization in writing, except to the extent that KQMC has already taken action in reliance thereon.

If you are unable to be reached by phone, may we leave you a message or mail to the address on file regarding appointment information? _______________

**Emergency Contact Number other than YOUR home phone number:** *(Please note, you are giving permission for this emergency contact to receive your personal health information if necessary.)* ___________________________________

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If for some reason the facility needs to relay my protected health information, i.e. lab results or billing issues, you can either leave or discuss the information with the following individual(s):

Name__________________________________ Number_____________________ Relationship____________________

Name__________________________________ Number_____________________ Relationship____________________

Name__________________________________ Number_____________________ Relationship____________________

**Medicare "B" Signature Authorization**

I authorize any holder of medical or other information about me to release to Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers, or to the billing agent of this physician or supplier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I understand this is a lifetime signature authorization.

**By signing below, you understand and consent to all of the agreements listed on this form**.

Patient or Guardian Signature_____________________________________ Date_______________________

Staff Signature__________________________________________________ Date_______________________