HOSPITAL
FOR
SPECIAL
SURGERY

Lana Kang, M.D. PC

420 East 72nd Street, New York, NY 10021

Patient Information

Name (Last, First, MI)				MR# (Office Use Only)	
Street Address					
City	State	Zip	Gender ☐ Male ☐ Female	Date of Birth	
Social Security #		Home phone #		Cell Phone #	
Work Phone #	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated		Occupation	Employer	

Pharm

Preferred Pharmacy :	Pharmacy Address:	Pharmacy Phone:

Emergency Contact

Name	Relationship to Patient
Daytime Phone #	Evening Phone #

Referring Info

Referring Physician's Name (if applicable)	Physician Phone #
Physician's Address (if known)	

Insurance Information

Primary Insurance Company	Policy #		Group #
Claims Address	City	State	Phone
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____		Name of Subscriber (if other than patient)	
Subscriber's Social Security #	Gender ☐ Male ☐ Female	Date of Birth	
Secondary Insurance Information	Policy #		Group #
Claims Address	City	State	Phone
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____		Name of Subscriber (if other than patient)	
Subscriber's Social Security #	Gender ☐ Male ☐ Female	Date of Birth	

Assignment of Benefits and Release

Please Read the following and Sign below

Assignment of Benefits and Release of Information

I hereby authorize my benefits to be paid directly to the undersigned physician. I understand that I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.

Medicare Patients

I authorize any holder of medical or other information about me to release for Medicare & Medicaid Services and its agents any information needed to determine benefits for this related Medicare claim. I request that payment of authorized Medicare benefits be made either to me or to the party who accepts assignment.

Financial Acknowledgement

By signing below, I acknowledge that I agree to the financial policy described at the end of this form.

Signature: _____ Date: _____

Name: _____

Reason for your Visit: _____

_____

Referred by: _____

Date of Onset or Injury: _____

Right of Left Injury? _____ Right or Left Handed? _____

Was this Work –Related? Yes / No Related to an Automobile Accident? Yes / No

MD NOTES:

Medical History			**Medical History (continued)**		
Diabetes	Yes	No	Osteoarthritis	Yes	No
Hypertension	Yes	No	Rheumatoid Arthritis	Yes	No
High Cholesterol	Yes	No	Osteoporosis	Yes	No
Heart Attack/Disease	Yes	No	Seizure/Epilepsy	Yes	No
Asthma	Yes	No	Cancer	Yes	No
COPD or Emphysema	Yes	No	Thyroid Disease	Yes	No
Hepatitis/Liver Disease	Yes	No	Other _____		
Kidney Disease	Yes	No			
Stomach Ulcers/Reflux	Yes	No	**Social History**		
Blood Clots	Yes	No	Do you smoke?	Yes	No
Bleeding Disorder	Yes	No	Packs per day _____		
Lupus/Crohn's/Psoriasis	Yes	No	Do you drink?	Yes	No
Depression	Yes	No	Drinks per day? _____		

Family History					
Diabetes	Yes	No	Cancer	Yes	No
Heart Disease	Yes	No	Neurological Disorder	Yes	No
Rheumatoid Arthritis	Yes	No	Stroke	Yes	No
			Blood Disorder	Yes	No

History of Surgery or Hospitalization? Yes No (please list below)

Surgical Procedure & Date	Reason

Allergies to drugs/products? Yes No (please list below)

Name	Reaction

Medications: Please list any prescribed or Over-the Counter Meds

Name	Dose	# times a day/week

Do you have problems with any of the following?

Vision/Hearing?	Yes	No	Gout or Rheumatoid?	Yes	No
Heart Rhythm?	Yes	No	Blood Clots?	Yes	No
Difficulty Breathing?	Yes	No	Bleeding or Anemia?	Yes	No
Digestion/Bowel?	Yes	No	Veins or Arteries?	Yes	No
Bladder Infections?	Yes	No	Back/Legs/Arms?	Yes	No
Hi/Low Blood Sugar?	Yes	No	Skin Disorders?	Yes	No
Thyroid/Adrenals?	Yes	No			

Additional Comments or Concerns: _____

Height?	Weight?	Pulse

Patient Signature: _____ Date: _____

Reviewed by: _____ Date: _____

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CONSENT FOR COMMUNICATION VIA E-MAIL (PROVIDER, STAFF -PATIENT)

I, _____ hereby consent to have Lana Kang, MD and her staff, where appropriate communicate with me or members of her staff, other physicians and pharmacies Via E-mail regarding the following aspects of my medical care and treatment: Test results, prescriptions (also submitted electronically to pharmacies), appointments, billing, etc.

I understand that e-mail is not a confidential method of communication. I also understand that there is a risk that e-mail communications between parties regarding my medical care may be intercepted by third parties or transmitted to unintended parties. I understand that in an urgent or emergent situation I should call my provider or go to the emergency room and not rely on e-mail. I am also aware that my provider and staff members will only reply to e-mails during normal business hours Monday-Friday 9:00AM-4:00PM with the exclusion of Holidays.

Patient Name: _____

Parent/Guardian Name: _____

Patient/Guardian Signature:_____

E-Mail Address: _____

Date: _____

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Please advise us if you change your address, phone number, place of employment or insurance companies.

Financial Policy

Dr. Kang participates with a variety of insurance programs that are popular in the tri-state area. We will do our best to assist you; however the responsibility for payment of fees for services is the direct responsibility of the patient. You should be knowledgeable of your plans specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations, limits on outpatient charges, or specific physician to use.

Payment

- If we participate with your insurance plan, we will file an insurance claim for you. At the time of your visit, we expect payment for your co-payment or co-insurance percentage or portion that is not covered by insurance.
- Patients without insurance or patients with insurance plans in which we do not participate are expected to pay for charges at the time of service.
- We do not accept responsibility for charges denied as a result of changes in your insurance coverage during the course of your treatment. Denials due to changes in your insurer and/or managed care organization are your financial responsibility.
- Past due balances are due at the time of your visit.

Referrals/Insurance

I understand that payment of fees is my responsibility. I am responsible for obtaining the necessary requirements my insurance plan requires. If I do not provide the referral required or if my insurance is no longer valid, I am responsible for paying for the services I am requesting.

Other Fees

- Some insurers do not pay for supplies such as braces, splints, crutches, etc., that are provided by our office. In the event that your insurance company is billed and does not remit payment, you will be billed for the supplies that are not paid for.

Lana Kang MD

Hand & Upper Extremity
420 E72nd Street, Suite 1B
New York, NY 10021
Phone: 212-203-0747; Fax: 212-203-0739

Hospital for Special Surgery
535 E70th Street
New York, NY 10021
Phone: 212-606-1000

Dr. Lana Kang would like to ALERT you to the fact that most Insurance plans have changed the way they will pay for your medical care so that now YOU have MUCH GREATER financial responsibility.

1. There has been an increase in the Required Deductible that YOU must pay FIRST before the insurance company will pay for any medical services.

2. Most plans use a fee-schedule based on a percentage of Medicare rates. These rates are much lower than usual and customary rates; therefore, you will be left with a bigger balance bill. Your insurance plan may have notified you of this change, but other plans may not have given formal notification.

3. Therefore, this may leave You, the Patient, RESPONSIBLE to pay for the balance bill.

4. What's the bottom line? If you don't know by what method your plan is paying for your medical care, our practice now requires that you *find out & seek information* from your job and your insurance company exactly what your personal financial responsibility will be for the treatment you receive. We urge you to *first* learn the facts so that you are not left in a financial hole.

If you think that a plan based on Medicare fees is a bad deal, please let your employer know this, and let your Elected Representatives know, too.

_____ _____

Signature Date

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT WITH NEW AND ONGOING CHANGES IN INSURANCE POLICIES IMPOSED BY MY HEALTH CARE PLAN, ADDITIONAL FEES MAY BE ASSIGNED TO ME, THE PATIENT, FOR WHICH I AM RESPONSIBLE.

Lana Kang, MD

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Acknowledgment of Receipt of Disclosure of Alternative Diagnostic Imaging Providers

I, _____, have received a list of alternative providers on page 2 who
Patient Name

provide diagnostic imaging services comparable to those offered at the office of Lana Kang MD P.C. I understand that I may undergo diagnostic imaging at the provider of my choice, and that Lana Kang MD P.C. will provide me with the same standard of care regardless of which provider I choose to perform diagnostic imaging.

By: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Name of Patient or Legal Guardian Date