SHALOM MEDICAL CORPORATION

DAVID S. HAN, MD

ESTHER YOON MD INC.

Patient Demographics Form

Patient Information

Date: _____

Name: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip: _____

May we leave messages?

Home Phone: (_____) _____ - _____ ☐ Yes ☐ No

Cell Phone: (_____) _____ - _____ ☐ Yes ☐ No

Work Phone: (_____) _____ - _____ x_____ ☐ Yes ☐ No

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Sex: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Unknown

E-Mail: _____ (Providing your e-mail address will give you access to our Patient Portal which allows you to set appointments, request prescription refills, and view medical records online.)

Primary Care Physician: _____ Referring Physician: _____

Employer Name: _____ ☐ Part-Time ☐ Full-Time ☐ Retired ☐ Student

Responsible Party: ☐ Self ☐ Guarantor

Guarantor's Name: _____ Relationship: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: (_____) _____ - _____

Primary Insurance: _____ Secondary Insurance: _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: (_____) _____ - _____

Pharmacy Name: _____

Address: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

How did you hear about us?

☐ Flyer ☐ Yellow Pages ☐ Internet ☐ Glendale Memorial Doctor Finder

☐ Friend _____ ☐ Other _____

I hereby authorize the doctor's office to release any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _____
Patient, please sign for permission to treat

_____
If signed by other than patient, please write name and relationship

SHALOM MEDICAL CORPORATION DAVID S. HAN, MD

ESTHER YOON MD INC.

Office Procedure and Financial Policy

Thank you for choosing us for your healthcare needs. The goal of the doctors and staff of Shalom Medical Corporation /Esther Yoon MD, Inc. is to provide the best possible medical care for you and to develop and maintain a relationship with you that will grow and strengthen through the years ahead. Along with our medical relationship, we will be establishing a financial relationship. In order to successfully maintain this relationship, we want you to have a clear understanding of our financial policy. We ask that you read, understand, and sign this policy statement prior to any treatment.

Insurance Verification

It is your responsibility to verify with your insurance carrier prior to your appointment that our physicians are participating providers with your specific plan. You are responsible for **thoroughly understanding** your insurance benefits. This includes what services your insurance **will or will not cover** and any special facilities that need to be utilized for labs and x-ray services that the doctor might order for you. This is important as we cannot be responsible for services that are not covered by your insurance plan or for services provided at non-contracted facilities. **Also be advised that all co-payments are due at the time of service.**
As a courtesy to our insurance patients, we will bill both primary and secondary medical insurances. However, in order for us to bill for an appointment, you must submit proof of current insurance coverage at the time of the visit. Without current proof of coverage, payment for the services will be required at the time the service is rendered. If insurance information is submitted after the date of service, we will gladly bill your insurance and refund your payment.

Financial Policy

Prior credit card payment authorization for missed copays, additional charges/fees (i.e. 'Walk-In', 'No Show', Form, etc.), and unpaid balances beyond 90 days from the date of service is now required. Please read the attached 'Payment of Services' sheet, sign the 'Credit Card Authorization' form, and return it to our front office staff prior to seeing the doctor today. For your convenience, we accept cash, checks, VISA, Mastercard, and Discover. There is a **$30.00** charge for all returned checks.

Cancellation Policy

A specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, please give us **at least 24 hours notice** so that we may reschedule your appointment and offer the reserved time to another patient. It is our policy to charge for appointments that have been scheduled in advance and are cancelled with less than 24 hours notice. The charge will be **$50 per missed appointments and no show appointments** and it is not covered by insurance. Therefore, you will be held responsible for the charge. **New patients will have the opportunity to reschedule/no show up to two times. Thereafter, we will not be able to service you in our office.**

Additional Health Issues Addressed During Preventative Care Appointments

Preventative care is an important part of your good health. We recommend and follow the schedule established by the American Academy of Family Practice. Unfortunately, through the years, insurance companies have continued to limit the scope of issues that they will cover during these preventative care exams. **Other health issues that are addressed during preventative care appointments will be billed as a separate office visit along with your preventive care visit.** Please be aware that some insurance companies may require that patients pay **separate co-pay for this office visit. If you have extra issues to discuss, please inform the staff so that they can schedule additional time for your concerns.**

Unscheduled Appointments

We discourage walk-in appointments. Appointments requested in the office without prior arrangement will be made according to our discretion with consideration given to other patients' scheduled appointments and the severity of your illness. In all instances, a **$30.00 walk in-fee** will be charged. This fee is not covered by insurance and is due at the time of service.

Follow Up Appointments
In order for our doctors to provide the best of care to you, it is important to keep your follow up appointments. For this reason, we will **not** be able to refill any prescriptions or order any tests if you have not been seen at our office for **over a year.**

Telephone Consultations
There may be a consultation charge for complex or lengthy telephone calls with the doctor to discuss your health problems. We will be glad to bill your insurance company, however, if these charges are not covered under your health plan, you will be responsible for the payment.

Guardian Requirements
Children under 18 years of age must be accompanied by a legal guardian to all visits to our office. If someone other than a legal guardian will be bringing your child to an appointment, we must have a written authorization signed by a legal guardian in your child's medical chart authorizing this individual to act on behalf of the child's guardian in order to treat your child. Whoever brings the child into the office is responsible for co-payments and for having a current insurance card at the time of service.

Completion of Forms and Request for Medical Records
If you have forms for our doctors to complete (camp, school, work, DMV, etc.), please be advised that there is **an administration fee of $30 per form** and **a turnaround time of 3-5 business days.** If forms are needed sooner, there will be an additional charge. There is also a fee for duplication of medical records per patient if records are to be picked up. An additional fee will be charged if the chart is exceptionally large or if you request that the records be mailed.

Reporting to Court
The doctors of Shalom Medical Corporation/Esther Yoon MD, Inc. will not report to court for any lawsuits related to the accident or medical condition you were evaluated for. We will provide necessary medical and billing records per your written request.

Maintaining a Respectful Environment
We strive to treat our patients with courtesy and respect. It is also important that we ensure that our staff is treated with respect from our patients as well.
We feel very strongly that our staff works in an environment free from verbal and physical abuse.
Angry outbursts against our staff **will not** be tolerated and may result in your discharge from the practice.

Acknowledgement of Receipt of Notice of Privacy Practices
Our office enforces the HIPAA (The Health Insurance Portability and Accountability Act of 1996) Privacy Rule to protect your health information. Detailed information about it can be given to you to read per your request. By signing below, you acknowledge that you were given the opportunity to read a copy (or receive a copy upon request) of the Notice of Privacy Practices and that you have read and understood the Notice.

I have reviewed the above information, understood my responsibility for the payment of my account, and agree to abide by the policy outlined above.

_____ _____
Patient Full Name (Please Print) Date

_____
Parent or Guardian Full Name (For Minors)

_____
Signature of Patient or Parent/Guardian

Personal Health History

Name: _____ Date of Birth: _____ Date: _____

Please answer the following questions to the best of your ability.

Allergies:

To What?	Type of Reaction

Current Medications:

Name	Strength	Frequency

☐ For additional medications, please check this box and list them on the back to this form.

Medical History

Vaccinations:

Hepatitis A	☐ Yes	☐ No	☐ Don't Know	☐ Date of last _____
Hepatitis B	☐ Yes	☐ No	☐ Don't Know	☐ Date of last _____
Tetanus	☐ Yes	☐ No	☐ Don't Know	☐ Date of last _____
Flu	☐ Yes	☐ No	☐ Don't Know	☐ Date of last _____
Pneumovax (Age 50+)	☐ Yes	☐ No	☐ Don't Know	☐ Date of last _____

Skin Test for TB?	☐ Yes	☐ No	☐ Date of last _____	☐ Positive	☐ Negative

Have you ever had or do you have now?

Skin Problems	☐ Yes	☐ No	Colonic Polyps	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Intestinal Disease	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No	Syphilis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Gonorrhea / Chlamydia	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Peptic Ulcer Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Problems	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Gout	☐ Yes	☐ No
Gallstone	☐ Yes	☐ No	Other _____	☐ Yes	☐ No

Operations/Surgeries: **Hospitalizations:**

Type	Year	Reason	Year

Name: _____ Date of Birth: _____ Date: _____

Family History

Family Members:

Relationship	If Living (Age & Health)	If Deceased (Age at Death & Cause)
Father		
Mother		
Brother(s)		
Sister(s)		

Do you have a blood relative who has been treated for:

Cancer	☐ Yes	☐ No	Relation_____
Tuberculosis	☐ Yes	☐ No	Relation_____
Diabetes	☐ Yes	☐ No	Relation_____
Heart Trouble	☐ Yes	☐ No	Relation_____
High Blood Pressure	☐ Yes	☐ No	Relation_____
Stroke	☐ Yes	☐ No	Relation_____
Seizures (Epilepsy)	☐ Yes	☐ No	Relation_____
Bleeding Problems	☐ Yes	☐ No	Relation_____
Psychiatric Disorder	☐ Yes	☐ No	Relation_____
Asthma	☐ Yes	☐ No	Relation_____
High Cholesterol	☐ Yes	☐ No	Relation_____
Other _____	☐ Yes	☐ No	Relation_____

Social History

Martial Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse	Gender	Age	Health
Children	**Gender**	**Age**	**Health**

Do you have any major problems at home? ☐ Yes ☐ No
If yes, please explain _____.

What is your occupation? _____ Have you been injured at work? ☐ Yes ☐ No
Any major problems at work? ☐ Yes ☐ No If yes, explain _____.

What is your religion? _____

What is your sexual preference? ☐ Heterosexual ☐ Homosexual ☐ Bisexual

Do you smoke cigarettes? ☐ Yes ☐ Never ☐ Quit – When? _____
If yes, how much do you smoke? _____.

Do you drink alcoholic beverages? ☐ Yes ☐ No
If yes, how much do you drink? _____.

Have you ever used recreational drugs? ☐ Yes ☐ No ☐ Quit – When? _____

Do you exercise regularly? ☐ Yes ☐ No If yes, how often? _____

Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, how much do you drink? _____.

Name: _____ Date of Birth: _____ Date: _____

Review of Systems

Do you have problems with or have encountered the following in the last month:

Runny nose	☐ Yes	☐ No	Joint pain	☐ Yes	☐ No
Hearing Loss	☐ Yes	☐ No	Muscle pain	☐ Yes	☐ No
Ear Problems	☐ Yes	☐ No	Headache	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No	Dizziness	☐ Yes	☐ No
Fever / Chills	☐ Yes	☐ No	Depression	☐ Yes	☐ No
Weight loss	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Weight gain	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Excessive Fatigue	☐ Yes	☐ No	Cough	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No	Painful Urination	☐ Yes	☐ No
Palpitation	☐ Yes	☐ No	Frequent Urination	☐ Yes	☐ No
Rash	☐ Yes	☐ No	Difficulty Passing Urine	☐ Yes	☐ No
Abdominal Pain	☐ Yes	☐ No	Blood in Urine	☐ Yes	☐ No
Nausea / Vomiting	☐ Yes	☐ No	Loss of Control of Urine	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No	Swelling of Ankles	☐ Yes	☐ No
Constipation	☐ Yes	☐ No	Pain in Legs from Walking	☐ Yes	☐ No

For Ages 50 and Over:

Have you had a colonoscopy? ☐ Yes, when _____ ☐ No

For Women Only:

Age period started: _____ years old

Duration of Period: _____ days

Date of Last Period: _____

Age Period Stopped: _____ years old

Abnormal Menstrual Bleeding? ☐ Yes ☐ No

Date of Last Pap Smear: _____

Number of Pregnancies: _____ Deliveries _____ Abortions _____ Miscarriages _____

Use of Contraceptives? ☐ Yes ☐ No If yes, which one? _____

Vaginal Discharge or Itching? ☐ Yes ☐ No

Date of Last Mammogram: _____ Normal Mammogram? ☐ Yes ☐ No _____

Ever Taken Hormones? ☐ Yes ☐ No

Breast Lump or Discharge? ☐ Yes ☐ No

_____ _____

Patient's Signature Date

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Payment for Services

Working with multiple insurance companies has become increasingly challenging for medical practices. More and more delayed payments from insurance carriers and patients have placed a severe operational burden on private practices. Therefore, there is an increasing trend for private practices to terminate their affiliation with insurances carriers and become concierge private practices.

In order to continue our current contracts with insurance carriers, it has become necessary for us to establish limits on the length of time we carry outstanding balances for our patients. **Therefore, prior credit card payment authorization for missed copays, additional charges/fees (i.e. 'Walk-In', 'No Show', Form, etc.), and unpaid balances beyond 90 days from the date of service is now required.** Insurance patients are required by your health plan to pay your copay at the time of service. Any copay or additional charges/fees not paid at the time of service will be billed to your credit card on file on the same date of the service. We will also bill to the credit card on file all unpaid balances remaining on your account 90 days from the date of service. Receipts for all credit card charges will be mailed to the home address that we have on file in your chart.

Cash patients will need to pay in full at the time of service. For your convenience, we accept cash, checks, VISA, Mastercard, and Discover. There is a $30.00 charge for all returned checks.

We do realize temporary financial problems may affect timely payment of your account. If such problems do arise, please contact our billing service **immediately after receiving your first statement** for assistance in the management of your account. Payment plans are available for hardship cases. Our billing department can be reached Monday through Friday at (818) 726-8141.

Please complete and sign the attached **Credit Card Authorization** form and return it to the Front Desk today.

Thank you.

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Frequently Asked Questions Regarding Our Credit Card Policy

Where will my credit card number be kept?
It will be kept in our secure electronic health record system that is password protected and only accessible by the doctors and staff of Shalom Medical Corporation/Esther Yoon MD Inc.

Are other practices doing this?
Yes, more and more practices nationwide are adopting this policy to ensure payment for rendered medical services.

Why am I being asked for this information?
When we provide care for you or your child, we are *extending credit to you for the services provided*. Unfortunately, some patients do not pay their medical bills to us at all. Every year, we are left with thousands of dollars in unpaid bills. The vaccines and medical supplies we purchase are expensive, the overhead for providing them is high, and we make little to no profit on them. When patients neglect to pay their bills, this increases our costs which ultimately get passed to the rest of the practice and its patients.

I always pay promptly. Why do I need to leave this number?
If you pay promptly, your credit card will never be billed.

What if I can't pay my bill within the 90 days allotted?
Please notify our billing office so that we can assist you with this matter.

I'm concerned about credit card fraud.
We will make every effort to ensure that your credit card information is safe and secure. It will be only accessed in the event of non-payment. The risk of credit card fraud when giving a card at a restaurant or when making a purchase is far greater since the card number can be viewed by a greater number of people.

What if I am unwilling to leave a credit card number?
Unfortunately, we will not be able to continue to provide care for you or your child. Please keep in mind that if you pay your medical bills in a timely manner, your credit card will never be billed.

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Credit Card Authorization

I authorize **Shalom Medical Corporation/Esther Yoon MD, Inc** to bill my copay/co-insurance, 'Same Day Cancellation'/'No Show'/'Walk In' charges, Form/Medical Record Fees, and 90 day balance due to the credit card listed below. This authorization will automatically renew at the expiration date of the credit card and remain in force for all patients listed below until termination of care with Shalom Medical Corporation/Esther Yoon MD, Inc.

This information will be kept on file in our secure electronic health record system.

Type of Card (Please Circle One) VISA Mastercard Discover

Card Number _____ - _____ - _____ - _____

Expiration Date _____ / _____

Security Code (3 Digits) _____

Cardholder Billing Address _____

_____

Cardholder Name _____

Cardholder's Signature _____ Date _____

_____ _____ / _____ / _____
Patient's Full Name Patient's Date of Birth

_____ _____ / _____ / _____
Patient's Full Name Patient's Date of Birth

_____ _____ / _____ / _____
Patient's Full Name Patient's Date of Birth

_____ _____ / _____ / _____
Patient's Full Name Patient's Date of Birth

_____ _____ / _____ / _____
Patient's Full Name Patient's Date of Birth