Florence Kimbo M.D., LLC
Medical Arts Building I
18660 Bagley Road, Suite 404
Middleburg Hts., Ohio 44130
Ph: (440) 239-8746 Fax: (440) 234-8748
www.florencekimbomd.org

Patient #

Last Name _____ **First Name** _____ **Middle Initial** _____

Social Security Number _____ **Date of Birth** _____

Address _____ **City** _____

State _____ **Zip Code** _____

Phone Home# _____ **Cell#** _____ **Email:** _____

(Reminder calls for appointments are offered as a courtesy but are not guaranteed.)

PHARMACY INFORMATION: Name: _____ **City:** _____ **Ph:** _____

EMERGENCY CONTACT

Emergency Contact Name _____ **Relationship** _____ **Phone #** _____

I authorize "FKMD" to contact the above named person in case of emergency and to disclose the name of my doctor if necessary ▶ INITIALS _____

GUARANTOR (FINANCIALLY RESPONSIBLE PARTY) INFORMATION Please put "NA" if not applicable

You cannot financially obligate anyone other than yourself for these services if they are not present to sign this form.

If you wish to name someone other than yourself as GUARANTOR, they must be present to sign this form.

If patient is a minor the guarantor is the parent/guardian that brings the patient to their appointments and must sign form.

Check Here if Same as Patient (and Sign Below) ☐

Last Name _____ First Name _____

Relationship to Patient _____ Social Security # _____ Date of Birth _____

Address _____ City, State, Zip Co _____

Phone # Home _____ Cell _____ _____

Employer Name and Address _____

▶ GUARANTOR SIGNATURE _____ **DATE** _____

OVER PLEASE →

I understand that by not providing correct insurance information below, I may be responsible for the payment of fees not covered by my insurance. ▶ GUARANTOR INITIALS _____

PRIMARY INSURANCE INFORMATION

Name of Insurance _____ Effective Date _____

ID # _____ Group # _____

Phone #_____ Address for Claims_____

Is pre-authorization required for your insurance? _____ Authorization#_____

Do you have other / secondary insurance? ☐ If so enter information below.

PRIMARY INSURANCE POLICY HOLDER INFORMATION ***Check Here if Same as Guarantor*** ☐

Last Name _____ First Name_____

Date of Birth _____ Relationship to Patient _____

Address _____ City, State, Zip Code_____

Employer Name and Address _____

Phone # Home _____ Cell _____ Work_____

SECONDARY INSURANCE INFORMATION Please use **"NA"** in the fields that are not applicable

Name of Insurance _____ Effective Date _____

ID # _____ Group # _____

Phone #_____ Address_____

SECONDARY INSURANCE POLICY HOLDER INFORMATION ***Check Here if Same as Guarantor*** _____

Last Name _____ First Name _____ Middle Initial ____

Date of Birth _____ Relationship to Patient _____

Address _____ City, State, Zip Code_____

Employer Name and Address

_____

Phone # Home _____ Cell _____ Work_____

I certify that the information provided on both sides of this intake form is true and accurate to the best of my knowledge

▶ SIGNATURE _____ DATE_____

Florence Kimbo MD, LLC PRACTICE FINANCIAL POLICY

CO-PAY: All office co-pays are to be collected *at the time of service*. This is an insurance company policy. Whether your appointment is *In Person* or *Virtual* you will be asked for your copay *before* the session may begin. If we leave you a voicemail and do not hear back from you, before your appointment time, your appointment *may be canceled*, and you may be responsible for a late cancelation fee.

Coverage: The agreement of the insurance company to pay for medical care is between you and the carrier. We will submit insurance claims for our patients. However, you should direct any questions and or complaints regarding coverage to your insurance carrier, your employer, or you agent.

Insurance varies in their coverage for different services, and it is the patient's responsibility to understand their benefits. There may be limitations and exclusions to coverage. The patient portion is set by the insurance company, not by our company. Patients are responsible for any co-pays, co-insurance, deductibles, or any other non-covered billable services.

If you have a deductible: You may be asked to pay $65.00 for each visit until your deductible has been met. In mental health, you may see more than one provider in our office, and you may be seen *several times a month*. This up-front payment will help you manage your account balance so there is not an interruption in your ongoing services.

Late Cancelations and Missed appointments: Patients are responsible for notifying the office of any cancelations at least *24 hours prior* to their scheduled appointment. The Patient is responsible for the fees for any no-show or cancelations that occur within the 24-hour business hours of their scheduled appointment. As part of your treatment plan with your provider it is required that you attend all follow-up appointments to give you the most effective care. ***Reminders calls are a courtesy, not a guarantee.***

I have read and understand the financial policy of the practice and I agree to be bound by these terms. I understand that I am financially responsible for all charges whether or not they are covered by insurance and agree that such terms may be amended from time to time by the practice.

Signature: _____ Date: _____

Missed appointment fees can vary. They are set by the appointment type and provider type, from $75 to $150. Missed appointment fee will be collected prior to scheduling a future appointment with your provider(s).

Consent for Treatment and Coordination of Care

I give my permission for clinicians at Florence Kimbo M.D., LLC to evaluate and treat myself or my child (of whom I am legal custodian). I further authorize any test(s), procedure(s) and medication(s) as deemed necessary and mutually agreed to by clinicians at Florence Kimbo M.D.

SIGNATURE OF PATIENT/GUARDIAN _____ **DATE:** _____

MEDICARE and or MEDICAID PATIENTS ONLY

I request that payment of authorized Medicare benefits made on my behalf to Florence Kimbo M.D., LLC for any service furnished to my children or myself. I authorize any holder of medical information about me to be released to the Center for Medicare and Medicaid Services or its agents in order to determine benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If appropriate items of the HCFA-1500 claim form are completed, my signature authorizes release of information to the insurer or agency shown. In Medicare/Medicaid's assigned cases, I will be responsible for the amount remaining between Medicare's/Medicaid's payment and the Medicare/Medicaid's allowed charges, any deductible, co-insurance copayments and any non-covered services.

SIGNATURE of Patient/Guardian_____ **(Type "NA" if not applicable)**

Florence Kimbo M.D. LLC Medication Policy and Paperwork Policy

To provide you with safe and proper medical care, prescriptions can only be provided in coordination with regular office visits. *Refills of prescriptions will be issued at the time of a follow-up visit with your medical provider.*

Urgent requests for medication refills without an office visit ***will incur a $40.00 administrative fee****, non-reimbursable by insurance.* Please allow 48 hours to process your request. *Refill requests called in by a pharmacy will not be honored.*

A flat fee of $40.00 may be charged for any forms that a patient asks the Clinician to complete, such as *SSA, Disability papers, FMLA* or leave of absence forms. Only a medical doctor or Nurse Practitioner can complete and sign the requested paperwork. Please allow up to *5 days* after your appointment with your doctor for the completion of any forms.

Initialed as Read _____

Florence Kimbo M.D., LLC
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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer: The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information.

The right to amend your protected health information.

The right to receive an accounting of disclosures of protected health information.

The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of October 1, 2013 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information: For more information about HIPAA or to file a complaint: Florence Kimbo M.D., LLC Medical Arts Bld II, Suite 204 Middleburg Hts., Oh 44130 Office Manager: Kim Ellis (440) 234-8746.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, 200 Independence Avenue SW, Washington, D.C., 20201 or call toll-free (877) 696-6775, by e-mail to OCR Complaint @ hhs.gov, or to Region V, Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Ave., Suite 240, Chicago, Ill. 60601, Voice Phone (312) 886-2359, FAX (312) 886-1807,

(Initial as Read) _____