KENNETH T. KAAN, M.D., INC.

CONSENT TO RELEASE INFORMATION

This form is required in order to comply with federal health information portability and accountability (HIPAA) regulations. If not filled out completely and accurately, then the information in your chart will not be given out to anyone, which will prevent your physicians from receiving progress notes in a timely manner.

Patient's full name:	Social security no:	Birth date:

REFERRING PHYSICIAN

A copy of your progress notes will be sent to your referring physician.

Referring physician:	Phone number:

OTHER PHYSICIANS

The physicians and institutions below may access your progress notes upon request.

Primary care physician:	Phone number:
Other physician:	Phone number:
Other physician:	Phone number:

OTHER PARTIES

Kenneth T. Kaan, M.D., Inc. may contact the parties below regarding your status and care.

Other contact's name:	Relationship to patient:	Home phone no.:	Secondary phone no.:
Other contact's name:	Relationship to patient:	Home phone no.:	Secondary phone no.:
Other contact's name:	Relationship to patient:	Home phone no.:	Secondary phone no.:

By signing below, I provide Kenneth T. Kaan, M.D., Inc. and its employees permission to freely share my progress notes and other pertinent information regarding my health with the parties listed above. I have read a copy of the Health Insurance Portability and Accountability Act, which went into effect April 2003. I would like a copy of the HIPAA law, I may request it. This form will remain valid until I notify in writing that my progress notes no longer need to be sent to the parties mentioned above.

_____

Patient's name

_____ _____

Patient/Guardian signature *Date*

KENNETH T. KAAN, M.D., INC.

PATIENT REGISTRATION

Today's Date:	PCP and their phone no.:

Chose clinic because / Referred to clinic by: ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Online ❑ Other (specify)

Is this a Worker's Compensation or No-Fault Injury? ❑ Yes ❑ No

PATIENT INFORMATION

Patient's full name (last, first middle):		❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.		❑ Single ❑ Married	❑ Divorced ❑ Sep. / Wid. / Other
Preferred language:	Race:	Ethnicity:	Birth date:	Age:	Sex: ❑ M ❑ F
Street address:		Social Security no.:		Home phone no.:	
City:	State and ZIP code:	E-mail:		Cell phone no.:	
Occupation:	Employer:			Business phone no.:	

INSURANCE INFORMATION

Name of primary insurance:	Subscriber's name:	Sub. DOB:	Subscriber no:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			
Name of secondary/other insurance:	Subscriber's name:	Sub. DOB:	Subscriber no:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			

Please complete the section below if someone other than the patient is responsible for the payment of services.

Person responsible for bill:	Relationship:	Address (if different):		Home phone no.:
City:		State:	Zip Code:	Secondary phone no.:

IN CASE OF EMERGENCY

Emergency Contact:	Relationship to patient:	Home phone no.:	Secondary phone no.:
Alternate Contact:	Relationship to patient:	Home phone no.:	Secondary phone no.:
If the patient is a child, who may authorize treatment for this child?	Relationship to patient:	Home phone no.:	Secondary phone no.:

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes. I authorize Kenneth T. Kaan, M.D., Inc., its employees, and Team Praxis, to release to my insurance company, or its representative, any information including the diagnosis and the records of the treatment or examination rendered to me during the period of such medical or surgical care. I understand that even though I have insurance coverage, I am responsible for payment of services rendered to the above mentioned patient. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, Tricare, and private insurance and any other health plan to Kenneth T. Kaan, M.D., Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original. I understand that I will be assessed a bank interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to affect collection of this note. I hereby authorize Kenneth T. Kaan, M.D., Inc. and any of its employees to release all information necessary to secure payment and treatment.

_____ _____

Patient/Guardian signature *Date*

KENNETH T. KAAN, M.D., INC.

PHYSICAL EXAM

Patient's full name:	Today's date:	Birth date:

PRIMARY COMPLAINT

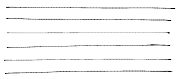
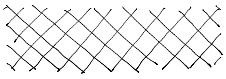
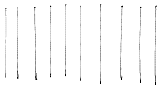
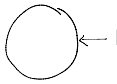
Description of primary complaint:

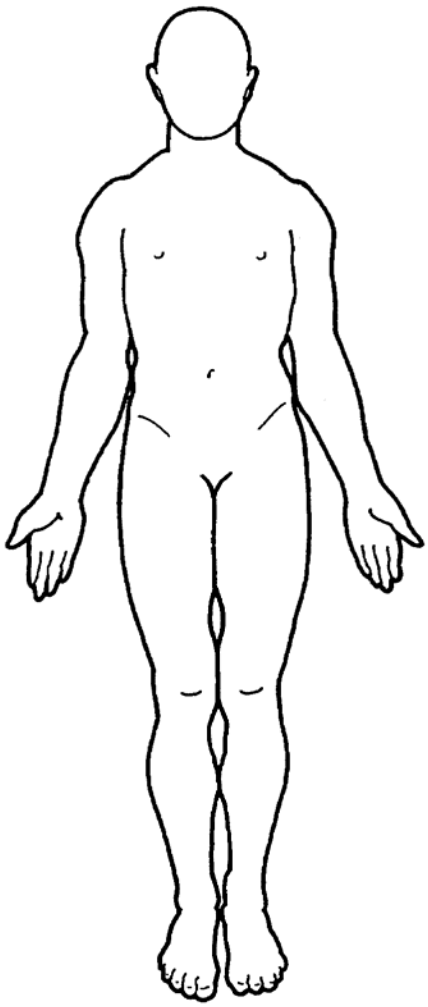
Do you have a specific injury? If so, describe its nature:

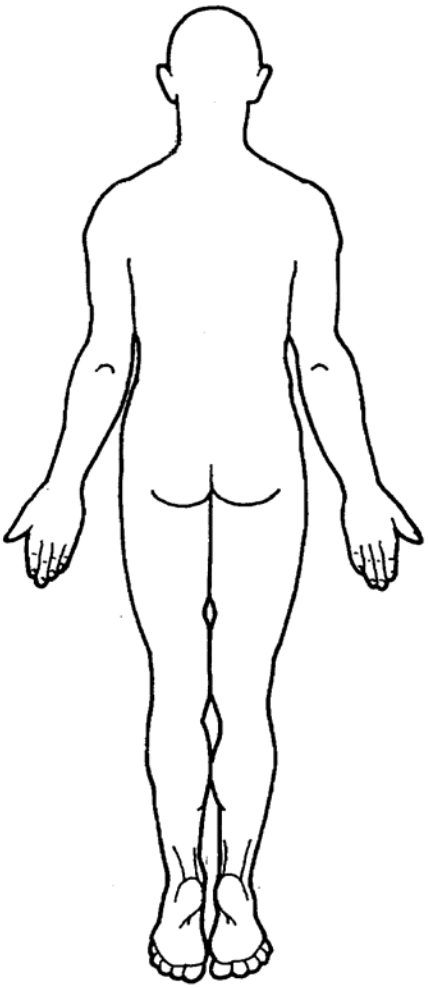
Date of onset of problem:	Height (inches):	Weight (pounds):	

SYMPTOM MAP

Please mark symptomatic areas of your body, and use the symbols listed below to represent specific sensations. Be sure to provide accurate areas of radiation and a complete visual description of your complaint. If you need to explain something, please feel free to further annotate. To complete the illustration, draw a face that matches your feeling (discomfort, agony, etc.)

Aches	Pins and needles	Burning	Stabbing	Other
				 Description





KENNETH T. KAAN, M.D., INC.

PATIENT HISTORY

Patient's full name:	Today's date:	Birth date:

PAST MEDICAL HISTORY

Please indicate if you suffered from any of the following conditions.

Heart disease	❑ Y ❑ N	Lung disease	❑ Y ❑ N	Diabetes	❑ Y ❑ N	Are you claustrophobic?	❑ Y ❑ N
Liver disease	❑ Y ❑ N	Kidney disease	❑ Y ❑ N	Infectious disease	❑ Y ❑ N	Do you have metallic implants?	❑ Y ❑ N Item?
High Blood Pressure	❑ Y ❑ N	Gastritis/Ulcer disease	❑ Y ❑ N	Do/did you have a pacemaker/defibrillator?	❑ Y ❑ N	Have you had brain surgery?	❑ Y ❑ N Year?
Gout	❑ Y ❑ N	Bleeding disorder	❑ Y ❑ N	Have you had metal in your eyes?	❑ Y ❑ N	Have you had heart surgery?	❑ Y ❑ N Year?
Arthritic disorder	❑ Y ❑ N	Blood disease	❑ Y ❑ N	Do/did you have aneurysm clips?	❑ Y ❑ N	Have you had CAT scan before?	❑ Y ❑ N Where?
Cancer	❑ Y ❑ N	Clotting disorder	❑ Y ❑ N	Are you pregnant?	❑ Y ❑ N	Have you had an MRI before?	❑ Y ❑ N Where?

REVIEW OF SYSTEMS

Please indicate if you suffer any of the following conditions.

Seizures/ Convulsions	❑ Y ❑ N	Constipation	❑ Y ❑ N	Urinary incontinence	❑ Y ❑ N
Headaches	❑ Y ❑ N	Diarrhea	❑ Y ❑ N	Fecal incontinence	❑ Y ❑ N
Dizziness	❑ Y ❑ N	Black/ Red stools	❑ Y ❑ N	Numbness/Tingling	❑ Y ❑ N
Fainting spells	❑ Y ❑ N	Abdominal pain	❑ Y ❑ N	Weakness	❑ Y ❑ N
Chest pains	❑ Y ❑ N	Nausea/ Vomiting	❑ Y ❑ N	Reactions to anesthesia	❑ Y ❑ N
Shortness of breath	❑ Y ❑ N	Pain/ Difficulty with urine	❑ Y ❑ N	Family reaction to anesthesia	❑ Y ❑ N
Palpitations	❑ Y ❑ N	Blood in urine	❑ Y ❑ N	Fever/ Chills	❑ Y ❑ N
Cough	❑ Y ❑ N	Incomplete emptying of bladder	❑ Y ❑ N	Weight/Appetite loss	❑ Y ❑ N

PREVIOUS SURGERIES

Operation:	Date:	Surgeon:	Operation:	Date:	Surgeon:

CURRENT MEDICATIONS

Medication:	Mg:	Dose:	Medication:	Mg:	Dose:	Medication:	Mg:	Dose:

ALLERGIES

Are you allergic to any medications, materials, or other substances? If so, list:

FAMILY HISTORY

Are you aware of any history of illness within your immediate family? If so, describe:

SOCIAL MEDICAL HISTORY

Do you currently tobacco products? (e.g. cigarettes, pipes, smokeless)	❑ Y ❑ N	How much per day?
Have you used tobacco products in the past?	❑ Y ❑ N	What year did you quit?
Do/did you consume alcohol?	❑ Y ❑ N	How much per day?

KENNETH T. KAAN, M.D., INC.

OFFICE POLICIES

The following policies have been in effect since January 2013. They were implemented to outline and clarify various details regarding our operations. Please take a moment to read this document carefully before signing below.

NO-SHOW / CANCELLATION

1. We require a 24-hour notice to cancel an appointment. If we do not hear from you within 24-hours or if you miss your scheduled appointment, then we will consider it a "NO SHOW." If you are late for your appointment, whether or not you call, you will be considered a "NO SHOW". You may reschedule to another day or wait to be worked into the same day's schedule.
2. Following a "NO SHOW," you will be directly assessed a charge of $25.00 per visit, which will be due prior to your next appointment. Your insurance will not pay for missed appointments.
3. We require a 2-week notice to cancel or reschedule any type of surgery. If you cancel or reschedule within 48 business hours (e.g. if you have surgery on Monday and you cancel/reschedule on the Thursday or Friday prior, you will be charged) from the day of surgery, you will be directly charged at a rate of $250.00. Your insurance will not pay for cancelled or rescheduled surgeries.
4. If you do not make any attempt to resolve your "NO SHOW" or "CONSISTENT RESCHEDULING" visits or if you repeatedly "NO SHOW", our office will have no other option but to terminate your care with Kenneth T. Kaan, M.D., Inc. and make other arrangements for your further treatment with another physician or health care facility, depending upon individual circumstances.
5. FOR MEDICARE AND QUEST PATIENTS ONLY: In order to give patients with serious medical problems the opportunity for an appointment, we require a 24-hour notice prior to your scheduled appointment for cancellations. Your appointment will be considered a "NO SHOW" if you miss your scheduled appointment without providing us with the minimum 24-hour notice. After three "NO SHOW" appointments our office may make alternative arrangements for your further treatment.

FORMS

1. All forms which require Dr. Kaan's signature will be available for pickup on the Tuesday after a request is submitted. There is no fee for signature-only requests.
2. All forms which need to be filled out will be handled for a rate of $10.00 (cash only) per form payable at the time of release. Each form is considered a separate item, and will be worked on in the order that it is received. If you have any forms that require immediate attention, please let our staff know; we will make every effort to expedite its handling. These forms will be available for pick up on the Wednesday after a request is submitted.

MEDICAL RECORDS REQUEST

1. Anyone requesting copies of medical records must have an authorization of release signed before documents are released.
2. We charge a base $25.00 for printing, preparation, and shipping (if applicable), plus $1.00 per page printed and additional shipping charges if the record exceeds 25 pages.

CO-PAYMENT

1. All co-payments are due prior to being seen by Dr. Kaan. If you're enrolled in a plan other than Medicare or Medicaid, expect a co-pay. If you do not know your coverage type or co-pay, please contact our staff.
2. If you are unable to make your co-payments at the time of your visit, please inform our staff.

BALANCE DUE

1. In order to reduce the cost of mailing out monthly statements, you have the option to pay your current balances at the time of your office visit. We will ask you if you would like to receive your balance at the beginning of your scheduled appointment so you can determine if you would like to pay.
2. We accept cash, checks, money orders, traveler's checks, Visa, and MasterCard as forms of payment.

NO INSURANCE

1. If your insurance is pending, we will ask for a cash deposit in good faith. Your deposit amount will vary, depending on the situation. We will notify you this amount prior to your appointment.
2. You will be asked to complete and sign a "Promissory Note."
3. You must follow all instructions on the Promissory Note to ensure the return of your deposit. If you fail to notify us or fail to adhere to the Promissory Note's instructions, you will forfeit your deposit and will be held responsible for payment in full for any outstanding balances.

By signing below, I, the patient or his/her responsible party, understand and agree with the policies above, and will do my best to comply.

Patient's name

Patient/Guardian signature *Date*