Today's Date: ____________________

Dr. Wilbur Kuo & Associates Internal Medicine
Patient Demographics

Name of Patient: First ___________________Middle_________________Last___________________Suffix________

Street Address:____

City: ____ State:___________________Zip:_____________________

Home phone#:___________________________________ Work phone #:___________________________________

Mobile/Cell phone #:______________________________ E-mail address:___________________________________

Sex: ☐ M ☐ F Date of Birth: ______________________Social Security Number: ___________________________

Marital status: ☐single ☐married, spouse's name: ____

Patient's Employer: ____

Work address: ____

City:_______________________________________State:___________________Zip:_________________________

Language Preference: ☐ English ☐ Other: _______________________________

Primary Ethnicity: ☐ African American ☐ American Indian or Alaska Native White ☐ Asian
☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Refused

Preferred Pharmacy (name and city): ____

Preferred Mail-Order Pharmacy (if any): ____

Dr. Wilbur Kuo & Associates Internal Medicine
Patient Insurance Information

Primary Insurance

Are you the primary subscriber? ☐ Y ☐ N (If NO, please complete the following for the primary subscriber)

Name of Subscriber: ________________________ Relationship to Patient: ________________________________

Subscriber's Date of Birth (needed for billing): ____

Subscriber Street address: ____

City: ______________________________________ State: ____________________ Zip: ______________________

Phone #: __________________________________ E-mail address: ______________________________________

Sex: ☐ M ☐ F Social Security Number: ____

Employer: ____

If our staff has your insurance card, you may skip this section:

Name of insurance: ____

Policy ID #/Member ID #: ____

Group # ______________________________ Co-pay ___________ Effective Date of Insurance _____________

Secondary Insurance (if any)

Are you the primary subscriber? ☐ Y ☐ N (If NO, please complete the following for the primary subscriber)

Name of Subscriber: ________________________ Relationship to Patient: ________________________________

Subscriber's Date of Birth (needed for billing): ____

Subscriber Street address: ____

City: ______________________________________ State: ____________________ Zip: ______________________

Phone #: __________________________________ E-mail address: ______________________________________

Sex: ☐ M ☐ F Social Security Number: ____

Employer: ____

If our staff has your insurance card, you may skip this section:

Name of insurance: ____

Policy ID #/Member ID #: ____

Group # ______________________________ Co-pay ___________ Effective Date of Insurance _____________

Dr. Wilbur Kuo & Associates Internal Medicine Consent and Assignment

Consent for Treatment: I hereby give consent to the physician and/or her is designee(s) for treatment and the administration of medication. I authorize you to give reasonable and proper medical care by today's standard. I understand that no guarantee or assurance has been made as to the result that may be obtained.

Assignment of Benefits and Authorization to Release Information: I authorize and assignment payment of medical benefits by my insurance company directly to Dr. Wilbur Kuo & Associates Internal Medicine for the services rendered, and authorize the release of medical information necessary to process the claim. I agree that a digital copy of this, the original authorization, shall be considered equally authentic. I further understand that I am responsible for any health insurance deductibles, co-insurance, co-pays, and **charges that my insurance deems non-covered charges**.

Financial Agreement and Legal Assignment:

- I understand that **copays are due prior to my visit.** I understand that **this office may require payment of deductibles prior to my office visit.** I understand that any amount collected at the time of service is an estimate only, and I will be responsible for any balance not paid by my insurance.
- I understand that once my insurance company has responded to my claim, any balance will be my financial responsibility. **I understand that it is my sole responsibility to understand what is or is not covered by my insurance.**
- I understand that normal office hours are 9am to 5pm Monday through Friday. I understand that this office may accommodate after hours appointments, but this office will submit an after hours charge for these accommodations.
- I understand that my new patient appointment will be billed to my insurance as a new patient visit and not as a preventative visit. If I wish to have a preventative visit in the future, I understand I can contact this office to schedule one. I understand that, as specified by my insurance company, preventative visits are screening visits which are limited in scope, and not the same as comprehensive physicals or a visit that discusses/prescribes medications, lab tests, or treatments for specific diagnoses. I understand that if I discuss any symptoms during a preventative visit, that as specified by my insurance company, that visit can no longer be billed as a preventative visit, but must be billed as a problem-based visit. I understand that this office has always incorporated thorough preventative care in our comprehensive physicals and follow-up visits and considers a separate preventative visit to be unnecessary.
- I understand that **balances are due within 30 days.** Accounts are considered past due after 30 days from the statement date. I understand that **past due accounts will be charged a $10.00 finance charge per month**.
- I understand that persistent failure to resolve a delinquent account either by payment in full or by a payment arrangement will result in dismissal from the practice.
- I understand that **accounting balances exceeding 90 days in age will be forwarded to a collection agency or attorney for collections and that all patients in the same responsible party may be discharged from the practice. I agree to pay all costs incurred in collecting unpaid balances and any and all court costs incurred therewith. I consider such costs reasonable. I agree that my contact information including cell phone number be provided to the collection agency and attorney for collections.**
- I understand that any returned check will be subject to a **$75.00 returned-check charge**.
- I understand that I will be subject to a **$25 no show fee** if I do not cancel an appointment with at least 24 hrs notice. I understand that multiple failed appointments will result in discharge from our practice.
- I understand that if I need financial assistance, I will contact this office **before** my balance is past due to discuss payment plans or health care credit plans such as carecredit.com.

The undersigned certifies that he/she has read the foregoing paragraphs and is the Patient, or Parent, or Legal Guardian of the Patient, or is duly authorized to execute and accept its terms.

____

Signature of patient or legal representative　　　　　　　　　　Date

Printed name of patient or legal representative: ____

If signed by legal representative, relationship to patient: ________________________________

Dr. Wilbur Kuo & Associates Internal Medicine
Acknowledgement of Receipt of Notice of Privacy Practices and HIPAA Compliance

I hereby acknowledge that I have received a copy of the Privacy Practices for Dr. Wilbur Kuo & Associates Internal Medicine in accordance with HIPAA regulations.

In an emergency, please contact:
Name: ________________________________
Phone number: ________________________________
Relationship: ________________________________

In compliance with HIPAA, I hereby authorize this office to release/share my medical information to the above person as well as the following persons:
Name: ________________________________
Phone number: ________________________________
Relationship: ________________________________

Name: ________________________________
Phone number: ________________________________
Relationship: ________________________________

If voice mail, an answering machine, or someone other than you or the persons you authorized in compliance with HIPAA answers the telephone, you request that we please:

- ☐ leave the name of the office and reason for the call, along with a detailed message, including test results and/or answers to my questions
- ☐ leave the name and number of the office and request that I call the office back
- ☐ leave the number of the office only and request that I call the office back
- ☐ do not leave any messages

I authorize messages stating that Dr Kuo's office has called my prescription into a particular pharmacy in a particular city. Such messages will not state the name of the prescriptions called in.

* Please be aware that depending on your carrier or service provider, text messaging, electronic mail, and voice mail/ answering machine privacy cannot be guaranteed.

____
Signature of patient or legal representative Date

Printed name of patient or legal representative: ________________________________
If signed by legal representative, relationship to patient: ________________________________

Dr. Wilbur Kuo & Associates Internal Medicine, LLC
Medical History

Allergies (include medications, radiology contrast media, other substances):

List your present medications, including name, strength, and how often you take them:

Dr. Wilbur Kuo & Associates Internal Medicine, LLC
Medical History

List Any Medical Illnesses (Past or Present):

List any surgeries, including types and dates:

List any hospitalizations, including reasons and dates:

Dr. Wilbur Kuo & Associates Internal Medicine, LLC
Medical History

Gynecologic History:

Age at onset of periods: _______________ Frequency: ______________________ Duration: ____________________

Number of Pregnancies: _______________ Number Births: ___________________ Number miscarriages: _________

Method of birth control: ____

Immunization History (list dates of your last vaccine):

Flu: ______________________________ Hepatitis A: ______________________________

Pneumovax 23: ______________________________ Hepatitis B: ______________________________

Prevnar 13: ______________________________ Shingles: ______________________________

Gardasil-9: ______________________________ Meningococcus: ______________________________

Tetanus/Diphtheria: ______________________________ Whooping cough (TdaP): _________________________

Family history:

Mother: ____

Father: ____

Brothers: ____

Sisters: ____

Children: ____

Preventive health:

Do you use tobacco products? □ Y □ N

If yes, what do you use and how much per day? ____

Do you drink alcohol? □Y □ N

If yes, what do you drink and how much per day? ____

Do you use drugs (marijuana, cocaine, heroin, etc.)? □ Y □ N

If yes, what do you use and how much per day? ____

Do you drink caffeinated beverages (tea, coffee, sodas, etc.)? □ Y □ N

If yes, what do you drink and how much per day? ____

Do you have a living will? □ Y □ N If yes, please provide a copy.

Do you have a Maryland MOLST form? □ Y □ N If yes, please provide a copy.

Do you have a medical power of attorney? □ Y □ N If yes, please provide a copy.

Are you an organ donor? □ Y □ N

Do you wear seat belts? □ Y □ N

Do you wear a bike helmet? □ Y □ N

Dr. Wilbur Kuo & Associates Internal Medicine, LLC
Medical History

Preventive health:

Do you exercise regularly? ☐ Y ☐ N

If yes, what type of exercise, how many times per week, and for how long? ______________________________

____

Have you ever engaged in an activity that put you at risk of getting HIV? ☐ Y ☐ N

If yes, explain: ____

Do you wish to be tested for HIV? ☐ Y ☐ N

What do you do for work? ____

Have you ever worked with chemicals, paints, asbestos, or other hazardous material? ☐ Y ☐ N

If yes, explain: ____

Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, or bruised) by your partner? ☐ Y ☐ N

Do you ever feel afraid of your partner? ☐ Y ☐ N

Provide the dates and results of the following (if known):

Last pap smear: ____

Last mammogram: ____

Last bone density: ____

Last colonoscopy: ____

Date next colonoscopy is due: ____

Last prostate check: ____

Last cholesterol check: ____

Last sugar check: ____

Last blood pressure check: ____

Last Cardiac Stress test: ____

Last Chest X-ray: ____

Last PPD (tuberculosis test): ____

Dr. Wilbur Kuo & Associates Internal Medicine, LLC
Authorization to Request Protected Health Information From Other Healthcare Provider

Patient Name: ________________________________ Telephone number: ________________________________

Date of birth: ________________________________

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. I authorize the following organization to make this disclosure:

   Name: ____

   Address: ____

   ____

   ____

   Fax Number: ______________________________ Phone Number: ______________________________

3. The type of information requested is the entire record except the following listed items:

   ____

   ____

4. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
   I wish to □ include □ exclude this information in my disclosure.

5. The information identified above is to be disclosed to **Dr. Wilbur Kuo & Associates Internal Medicine, LLC, 5963 Exchange Drive Suite 112, Sykesville, MD 21784. Phone number: 410-552-8126. Fax Number: 443-458-7220. E-mail: drkuomd@gmail.com Direct e-mail: wkuo@drkuomd.amazing-direct.com**

6. This information for which I'm authorizing disclosure will be used for the purpose of medical treatment of the above named patient by Dr. Wilbur Kuo & Associates Internal Medicine, LLC.

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Office Manager of Dr Wilbur Kuo & Associates Internal Medicine. I understand that the revocation will not apply to information that has already been released in response to this authorization.

8. Unless I specify differently, this authorization will expire on: ___________________. If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

9. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

____ ______________________________
Signature of patient or legal representative Date

If signed by legal representative, relationship to patient: ____

Dr. Wilbur Kuo & Associates Internal Medicine
Frequently Asked Questions

We strive to provide you with excellent care and undivided attention during your office visit. To this end, we have adopted certain practices guiding our service when you are not in our office but still require and deserve our time and attention.

1. How do I request a prescription refill?

You may request a refill by any of the following methods:

- Ask your pharmacy to contact us (But please verify they are contacting the right number)
- Send us a message through the patient portal
- Text our office at 410-552-8126
- Send us an e-mail at drkuomd@gmail.com
- Call our office and leave a message. Please make sure to leave us your full name, phone number, pharmacy name and city, prescription drug name, dose, and directions.

We send in refills only after office visits are finished for the day. This may be as late as 10 pm. We will send you an automated message once your refill has been called in. You may ask your pharmacy to notify you when your prescription is ready for pick up. Please be aware that some medications require frequent monitoring, and **make sure that you are up to date with your followup visits before requesting a refill.**

2. What if I need a prescription urgently?

Our first priority must be to patients who are in our office with acute medical concerns. **If you need a prescription urgently, and cannot wait until the end of the day, please call our office for a same day sick appointment.** We will then send your prescription in during your office visit. If you have a true medical emergency, please call 911 for an ambulance and emergency room evaluation and treatment.

3. How do I get a referral to a specialist?

- Most specialists and most insurances no longer require referrals. They may ask for an order, which simply states what we are asking them to evaluate and/or treat.
- **Most insurances require that we see patients for their concerns before we can issue a referral for them.**
- For referrals, we will need your specialist's name and address **as well as your appointment date.** Hence, referrals cannot be provided until you have an appointment time with the specialist.
- **We require 48 hrs notice to complete referral requests.** If you wait until you are in the specialist's office to request a referral, you will need to reschedule your specialist appointment.
- Most insurances now require referrals to be completed online. These referrals are automatically date-stamped by the insurance company's website. Hence, it not only violates our contractual obligations, but **insurance companies' online referral systems make it impossible for us to back-date referrals. Therefore, if your specialist requires a referral, and you do not request a referral from us until after you have already seen them and received treatment, you will be financially responsible for the entire cost of that specialist visit.**

Dr. Wilbur Kuo & Associates Internal Medicine
Frequently Asked Question

4. How do I get a form filled?

- You can send us your forms through the patient portal, by e-mail, by text, by mail, or by dropping them off.
- Unlike most other offices, we do not generally charge for form completion.
- **We require at least 48 hrs to complete forms submitted to our office.**
- If you must have a form completed in less than 48 hrs, you will be charged a $30 form fee.

5. How do I get my test results?

- We receive most test results within a few days. Some specialized tests may take a week or more.
- We will send you your results along with an interpretation and recommendations within a few days of receiving them.
- **The fastest way for you to receive test results is through the patient portal.** If you do not have a patient portal account, we will mail you a copy of your lab results. If we need to contact you urgently, we will call you.
- If it has been over ten days, and you have not heard about your test results, please contact us with your name and the name and location where your test was performed. Occasionally laboratory and radiology offices can lose your results or fail to report them to us.

6. Do you have late or weekend hours?

- Our normal office hours are 9am to 5pm.
- We will strive to accommodate requests for after hours appointments, but we will submit an after hours charge for the special accommodation as recommended to us by the insurance companies.
- We tried weekend hours previously, but due to lack of interest, we cancelled them.

7. How can I send your office HIPAA compliant private messages?

- Messages on the patient portal are HIPAA compliant.
- You can text our office number a request for a HIPAA compliant secure connection. You will then receive a text with instructions on how to login for secure texting.