New Patient Appointment and Physicals

Kassay Family Medicine

New Patient Appointment

Your initial appointment is an opportunity to meet with the doctor, discuss ongoing medical issues, gather family health history, review medications, obtain detailed personal information and get records from previous physicians. This appointment occupies a full 30 minutes **and does not leave time for a typical physical.** You can however schedule your 30 minute physical following your appointment.

Annual Physical (Preventative Care Visit)

What is a Preventive Care Visit?

- Your Preventive Care Visit (Physical) includes a routine physical exam, immunizations and services such that have been defined by the Patient Protection and Affordable Care Act.
- For a growing number of health plans, insurance providers will no longer be able to charge a copay, deductible or coinsurance for preventive services.
- Please be aware that if you have other health issues, your insurance may require Kassay Family Medicine to charge a copay for that visit.
- Check with your insurance company about what preventive services are covered by your plan.

Copay or No Copay:

"**HIDDEN COPAYS**" Even if a preventive test or screen is fully paid by insurance, you may still have a copayment or co-insurance for the doctor's office visit. That is, the preventive care is free, but the doctor's visit is not.

- Your Preventive Care Visit (Physical) which includes a routine physical exam and immunizations does not require a copayment.
- If you discuss symptoms of acute or chronic diseases at your Preventative Care Visit (Physical) it is considered "diagnostic" and you will most likely be required to pay a copayment.

Example: *Let's say you make a doctor's appointment specifically for a preventive service or test (Preventative Care Visit/Physical), but during the course of the visit you are treated for an unrelated problem, like the flu or changes in your diabetes medications. For this visit you would be required to pay the copayment for the office visit.*

New Patient Appointment and Physicals

Kassay Family Medicine

Kassay Family Medicine's Core Value:

- Treating the whole person is a core value at Kassay Family Medicine. We strive to address all of your concerns and properly investigate issues that arise during your visit.
- When patients come to see their health care providers for a Preventative Care Visit (Physical) they should expect the possibility that both preventive care and acute problems may be addressed during the same visit. Because of this copayment may be charged.

Reasoning behind the changes in coverage:

Americans get only about half the preventive services recommended by their health care providers, according to a 2003 report in the New England Journal of Medicine. The consequences are significant: A 2007 study by the Partnership for Prevention found that more than 100,000 lives could be saved annually by increasing the use of just five services: aspirin to prevent heart disease, smoking cessation assistance, screenings for breast and colorectal cancers, and flu shots.

One response by the United States Government is found in the Patient Protection and Affordable Care Act, passed on March 23, 2010. For a growing number of health plans, insurance providers will no longer be able to charge a copay, deductible or coinsurance for preventive services.

Despite these new regulations, there remains a lot of ambiguity — and not just amongst consumers — about what qualifies as preventive care. Because of this confusion, we encourage you to check with your insurance company about what preventive services are covered.

Complaints with copayments:

The decision of a copayment vs non-copayment for a visit is not decided Kassay Family Medicine; these decisions are based federal laws and insurance regulations. Complaints of this nature should be addressed with your insurance company.

Preventive Services Covered Under the Affordable Care Act:

Here's a good rule of thumb: *"If you discuss symptoms at your physical or if your provider orders a test, it's diagnostic and you'll most likely pay a copayment. If you have no symptoms, it's covered"*

Medical Record Release and Transfer

Patient's Name: _____

Address _____

Phone _____ Email _____

Birthday _____

Records From: _____

Address _____

Phone _____ Fax _____

Records To:

*unless otherwise requested, 2 years max

Kara Kassay MD
Phone: 503-675-1137

MAIL records to:
12511 SW 68th Ave **Portland, OR 97223**
OR
SECURE upload:
https://KaraKassay.com/send

The purpose of the use/disclosure is for _____
(initial all that apply)
I authorize the release of the information specified below to the individual, organization or agency named:

_____ 1 All medical records generated by this facility (**ONE YEAR + Vaccine Records please**)
_____ 2 Only some portions of medical records maintained at this facility (specify below)

_____

_____

I specifically authorize the release of information regarding the following condition/s **(please initial)**

_____ Drug Abuse if any
_____ Substance abuse if any
_____ Psychological or Psychiatric condition if any
_____ AIDS/HIV if any

Expiration or revocation of authorization - I understand that I may revoke this authorization at any time.
A copy of this authorization may be utilized with the same effectiveness as an original.

Print Name _____ Relationship to Patient _____

Signature _____ Date _____

*****MUST BE SIGNED*****

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

Kara M Kassay, M.D.

Medical History Form

Name: _____ DOB: _____ Date: _____

Current Medical Concerns: _____

Past Medical Conditions: _____

Past Surgical History: _____
Hospitalizations: _____
Injuries: _____

Current Medications and Dosage *(including Herbs, Vitamins)* : _____

Medication Allergies: _____

Family Medical History:

If deceased, age and cause of death

Father _____
Mother _____
Siblings _____
Children _____

Lifestyle History

Smoker _____ Quit Date _____ Other tobacco _____
Alcohol _____ Quantity _____ Frequency _____
Exercise _____ Activities _____ Frequency _____
Children _____ Ages _____ In a Relationship?(M/F) _____
Occupation _____

Exam History

Last Physical _____
Last Labs _____
Last Colonoscopy _____
Last Tetanus _____

Gyn History (women)

Pregnancies/Deliveries _____
Last Pap _____
Birth Ctrl /Type _____
Gardasil Shot _____

Last Bone Density _____
Last Mammogram _____
Last Menstrual Cycle _____

Kara M. Kassay MD

12511 SW 68th Ave
Portland, OR 97223

KASSAY FAMILY MEDICINE

Patient name _____ Email: _____

Address: _____

Street City State Zip Code

Would you like Dr. Kassay's newsletter? **Y / N**

Home Phone ( ) _____ Emergency Phone ( ) _____

Cell Phone ( ) _____ Drivers License number _____

Date of Birth / / Sex: **M / F** Marital Status _____

Social Security Number _____ Student: **Y / N** if yes **Full** or **Part-Time**

Referred by: _____

Occupation Information

Occupation: _____ Work Phone _____

Employer _____

Street City State Zip Code

Spousal Information

Spouse Name _____ Date of Birth _____ SSN _____

Spouse's Employer _____ Work Phone ( ) _____

Insurance Information (bring card and skip this step)

Primary Insurance _____

Claims Address _____

Street City State Zip Code

Insured's Name _____ Relationship to Insured _____

Insured's DOB _____ Insured's SSN _____

Insured's ID# _____ Insured's Group# _____

Insurance Checklist (call insurance if do not know answers)

1. Is Kara Kassay MD in network?
2. Do you need to assign Kassay as a P.C.P.?
3. What is your Copay?
4. Does your insurance accept Legacy Labs?
   (Medicare, UnitedHealthcare, MODA Beacon, some Providence do not.)

Authorization to Release Information
Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____

I certify the insurance information I have provided is correct

I permit a copy of this authorization to be used in place of the original. This authorization may only be revoked by myself or my insurance company in writing.

Signature: _____ Date: _____

Statement of Financial Responsibility

I understand that I will be responsible for payment of any allowable charge that my insurance coverage does not pay. I also understand I will be responsible for services rendered that are not considered a covered benefit by my insurance company.

Signature: _____ Date: _____

Kara M Kassay, MD, PC
12511 SW 68th Ave
Portland, OR 97223
Phone (503) 675-1137 º Fax (503) 534-1137

Kara Kassay, MD, PC

Financial Policy

12511 SW 68th Ave
Portland, OR 97223

Updated January 1, 2020

We are pleased to welcome you to our facility and let you know we are dedicated to providing you with the best medical care and a pleasant experience. The following is your agreement to Kara M Kassay MD PC's Financial Policy. We have excellent relationships with the majority of the major insurance plans and will bill them directly as a professional courtesy. You are our patient and we service you and as a result, you are ultimately responsible for paying for your care.

1. **Billing Insurance** I understand that I am financially responsible for and agree to pay for all services received by Kara Kassay MD PC. I acknowledge that payment is required at the time services are rendered unless other arrangements – such as the billing of insurance – have been made. Payment for services includes payment of applicable coinsurance, copayments and deductibles for participating insurance companies. My insurance benefits are my responsibility to understand and if my insurance denies coverage I am fully responsible for payment.
2. **Labs and Radiology** I understand that Dr. Kassay may recommend that I receive laboratory tests or radiology services either on site or sent out for processing. I understand I am free to obtain such tests or services from any location I choose. I understand that I will receive a separate bill from the laboratory, imaging center, or radiology practice, depending on the service I receive. Dr. Kassay is not responsible for the prices or payment of bills incurred for these tests or what level of reimbursement is interpreted by my insurance contractor.
3. **Delinquent Account / Collections** There is a $25.00/month billing assessment for bills past 30 days due and after 90 days will be sent to Metro Collections. Accounts sent to collections will access a $100 fee and I will need to pay my account in full before being seen for any non-emergency medical needs. Accounts out of collections may require pre-payment or deposit for future visits. I understand I may be asked to find another doctor if I repeatedly go to collections or am not making arranged payments on time. Payment plans require a credit card on file.
4. **Please Provide Minimum 4 Hours Notice of Cancellation:** There are situations out of my control that might cause me to miss an appointment. If I am unable to give 4 hours notice, I understand there is a one time

INITIAL ___ (Sign BACK --->)

allowance and any further appointments not cancelled with 4 hours notice, will be billed $95 to me. I acknowledge I may need to prepay $95 to reserve a non-emergency appointment

KASSAY
FAMILY MEDICINE

Please read and sign the following agreement.

I have been informed that my insurance company may deny payment for the services rendered. If my insurance denies payment, I understand I am responsible for the payment.

Patient Name_____ DOB _____

Patient Signature _____ Date _____

INITIAL ___ (Sign BACK --->)

Please retain for your personal records | 2020

Acknowledgement and Consent

I understand that Kara M. Kassay M.D., P.C. (referred to below as "The Practice") will use and disclose health information about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand and agree that the practice may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment
- Refer to, consult with, coordinate among and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-office health care.

I also understand that I have the right to receive and review a written description of how the practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other personnel of the practice, and my rights regarding my health care information.

I understand that the **Notice of Privacy Practices** may be revised from time to time, and that I am entitled to receive a copy of any revised **Notice of Privacy Practices**. I also understand that a copy or a summary of the most current version of the practice's **Notice of Privacy Practices** in effect will be available in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the **Notice of Privacy Practices**, and I understand that this practice is not required by the law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I <u>have received</u> a copy of the Notice of Privacy Practices.

Signature: _____ Date: _____

Kara M Kassay, MD, PC
12511 SW 68th Ave | Portland, OR 97223
Phone (503) 675-1137 ° Fax (503) 534-1137

Kara Kassay, MD, PC

Phone Release

Family Medicine **503.675.1137 (P) 503.534.1137 (F)**
12511 SW 68th Ave
Portland, OR 97223
503.675.1137 (P) 503.534.1137 (F)

I, _____, authorize Dr. Kassay's office to leave a detailed phone message including test results at the following private phone line (___)_____. I may revoke authorization at any time.

_____ _____

Patient Signature *Date*

Kara Kassay, MD, PC

Cell Text / Email opt-in

I understand Kassay Family Medicine will send me phone text reminders on the day of my appointment and on rare occasion send necessary information. You *may* be included in group notifications such as quarterly newsletter or specific insurance updates we discover. At any time you can OPT OUT of any of these by replying STOP or CANCEL or of course, calling us and requesting being removed. Your email will *never* be shared or available to anyone outside the Family Medical Clinic of Dr. Kassay.

_____ ( ) *Please DO NOT send me future e-newsletters*

Patient E-mail Address

**Be sure to 'LIKE' Dr. Kassay's Facebook page to receive timely information.*

2020