

Kara M. Kassay MD

4309 Oakridge Road
Lake Oswego, OR 97035

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

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# _____

Secondary Insurance

Secondary 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# _____

Medical History Form

Name: _____ DOB: _____ Date: _____

Current Medical Concerns: _____

Past Medical Conditions: _____

Past Surgical History: _____
Hospitalizations: _____
Injuries: _____

Current Medications (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 _____
Occupation _____

Exam History (ALL)

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

Gyn History (women)

Pregnancies/Deliveries _____
Last Pap _____
Birth Control _____
Gardasil Shot _____

Last Bone Density _____
Last Mammogram _____
Last Menstrual Cycle _____

Financial Waiver

Kara M Kassay, M.D., P.C.
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Due to the various differences in insurance plans, it is necessary to inform you that some office visits and procedures performed in our office may not be covered under your insurance plan. If your insurance denies any claims, it will be your responsibility to file further requests for coverage with your insurer.

Your insurance may not cover preventative care services, such as physicals and gynecological evaluations. It is the responsibility of the patient to verify coverage prior to your visit.

Please provide 24 hour notice if you cannot make an appointment. Same day cancellations or not arriving for an appointment will be billed \$50. This will not be paid by your insurance and will be the patients/guarantor's fee.

Balances carried over 120 days will accrue a \$5.00/month collection fee.

Please read and sign the following statement.

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 for payment.

Medicare may pay for annuals and physicals; it will be your responsibility to pay for those services. I have been informed by the front desk of this policy and agree to pay for these services.

_____ Please initial

Patient Name _____

DOB _____

Patient Signature _____

Date _____

Medical Record Release and Transfer

Patient's Name:

Address _____

Phone _____ Email _____

Birthday _____ Social Security _____

Records From:

Address _____

Phone _____ Fax _____

Records To:

Kara Kassay MD

4309 Oakridge Road

Lake Oswego, OR 97035

Phone: 503-675-1137 Fax: 503-534-1137

(Please mail records > 20 pages)

The purpose of the use/disclosure is for _____

I authorize the release of the information specified below to the individual, organization or agency named on this request: **(initial all that apply)**

- _____ 1 All medical records generated by this facility
_____ 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 _____ Psychological or Psychiatric condition if any
_____ Substance abuse 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.

Charges may be incurred for copying costs. The rate is \$30.00 for the first ten pages, \$0.50 per 11-49 and \$0.25 per page thereafter. Fees are determined by the number of pages allowed by state law. There is no charge for records transferred between healthcare providers.

Print Name _____ Relationship to Patient _____

Signature _____ Date _____

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
4309 Oakridge Road
Lake Oswego, OR 97035
Phone (503) 675-1137 ° Fax (503) 534-1137*

Kara Kassay, MD, PC

Phone Release

Family Medicine
4309 Oakridge Road
Lake Oswego OR 97035
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

E-Mail opt-in

Family Medicine
4309 Oakridge Road
Lake Oswego OR 97035

503.675.1137 (P) 503.534.1137 (F)

I understand that the Family Medicine Clinic of Dr. Kassay will be transitioning to Electronic Medical Records. Future invoices, lab results and appointment reminders may be securely emailed. You *may* be included in group notifications. Your email will *never* be shared or available to anyone outside the Family Medical Clinic of Dr. Kassay.

Patient E-mail Address

() Please send me future e-newsletter

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-effective 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 have received a copy of the Notice of Privacy Practices.

Signature: _____

Date: _____

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