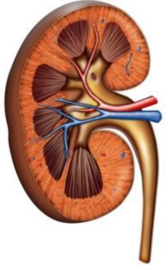
Caritas Medical Center, LLC



KIDNEY DISEASE AND HYPERTENSION SPECIALIST
105 NORTH PARK TRAIL · SUITE 300 · STOCKBRIDGE, GA 30281
OFFICE: 678·284·0800 FAX: 678·284·9299
WWW.CARITASMED.COM

DR. LEO OVADJE
DR. JUN-KI PARK
LATASHA JEFFERSON NP

Patient's please be advised, in order for our Providers to remain on schedule, it is very important that you complete your new patient paperwork prior to your appointment. If unable to complete prior to appointment, please arrive 15-20 minutes early to allow time to complete.

Please make sure you complete your packet prior to appointment. Please bring your insurance card, photo ID, and all medications. **Also be prepared to pay copay at time of service. However, if your deductible for 2018 hasn't been met, we will collect more than the standard copay. This cost will be collected up front, because we do not bill for copays or deductibles.** If you have any questions, please feel free to call our office.

You can also check out our website: http://www.caritasmed.com

Thanks,

Office Administration

CARITAS MEDICAL CENTER LLC

LEO O. OVADJE M.B.B.S. **JUN KI PARK M.D.**

NAME ____________________

CONSTITUTIONAL

Has there been any changes in your insurance O Yes O No

Has there been any changes in your address O Yes O No

Have you had any lab work done recently from another doctor O Yes O No

Weight gain	O Yes	O No
Loss of appetite	O Yes	O No
Fever	O Yes	O No
Weakness	O Yes	O No
Weight loss	O Yes	O No
Fatigue	O Yes	O No

ENT

Nose bleeds	O Yes	O No
Hearing loss	O Yes	O No
Change in voice	O Yes	O No
Sore throat	O Yes	O No
Ringing in ears	O Yes	O No
Sinus pain	O Yes	O No

CARDIOLOGY

Dizziness	O Yes	O No
Chest pain	O Yes	O No
Palpitations	O Yes	O No
Leg swelling	O Yes	O No
Shortness of breath	O Yes	O No
Varicose veins	O Yes	O No

GASTROENTEROLOGY

Blood in stool	O Yes	O No
Diarrhea	O Yes	O No
Vomiting	O Yes	O No
Constipation	O Yes	O No
Nausea	O Yes	O No
Difficulty swallowing	O Yes	O No
Abdominal pain	O Yes	O No
Heartburn	O Yes	O No

DERMATOLOGY

Rash	O Yes	O No
Lumps	O Yes	O No
Skin cancer	O Yes	O No

ENDOCRINOLOGY

Excessive thirst	O Yes	O No
Weight loss	O Yes	O No
Cold intolerance	O Yes	O No
Heat intolerance	O Yes	O No

NEUROLOGY

Headache	O Yes	O No
Tingling numbness	O Yes	O No
Seizures	O Yes	O No
Dizziness	O Yes	O No
Memory loss	O Yes	O No
Abnormal walk	O Yes	O No

OPTHALMOLOGY

Diminished vision	O Yes	O No
Drainage from eyes	O Yes	O No
Blurring of vision	O Yes	O No

RESPIRATORY

Shortness of breath	O Yes	O No
Chest pain	O Yes	O No
Chest congestion	O Yes	O No
Cough	O Yes	O No

ALLERGY

Itchy eyes	O Yes	O No
Runny nose	O Yes	O No

HEMATOLOGY/LYMPH

Swollen glands	O Yes	O No
Easy bruising	O Yes	O No

UROLOGY

Difficulty urinating	O Yes	O No
Blood in urine	O Yes	O No
Frequent urination	O Yes	O No
Urinary incontinence	O Yes	O No
Kidney/bladder infection	O Yes	O No
Excessive urination at night	O Yes	O No

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PLEASE FILL IN BUBBLE COMPLETELY

Social History

Occupation exposure:	**O Yes**	**O No**
Travel outside US:	**O Yes**	**O No**
Alcohol:	**O Yes**	**O No**
Smoking:	**O Yes**	**O No**
Exercise:	**O Yes**	**O No**

Past Medical History

Asthma	**O Yes**	**O No**
Hypertension	**O Yes**	**O No**
CHF	**O Yes**	**O No**
COPD	**O Yes**	**O No**
Arthritis	**O Yes**	**O No**
UTI	**O Yes**	**O No**
Acid reflux	**O Yes**	**O No**
Migraine headache	**O Yes**	**O No**
Dizziness	**O Yes**	**O No**
Low back pain	**O Yes**	**O No**
Seizures	**O Yes**	**O No**
Kidney stones	**O Yes**	**O No**
Sinusitis	**O Yes**	**O No**
Cancer	**O Yes**	**O No**
Kidney disease	**O Yes**	**O No**
Dialysis, CAPD	**O Yes**	**O No**
Transplant, kidney	**O Yes**	**O No**
Diabetes, Type 1	**O Yes**	**O No**
Diabetes, Type 2	**O Yes**	**O No**

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LEO O. OVADJE M.B.B.S. **JUN PARK M.D.**

KIDNEY, HYPERTENSION, INTERNAL MEDICINE

Patient Information

Patient Name: Last _________________________________ First __________________________ MI ____

Address: ________________________________ City, State, Zip_____________________________________

Social Security # ______________________ Birth Date: _________________________________

Male ____ Female ____ Married ____ Single ____ Divorced _____ Widowed _____

Phone (Home): _________________ Work: ____________________ Cell: ___________________

Email address: ____

Pharmacy: _______________________________City:___________________ Phone: ________________________

Primary Care Doctor: __________________________________Office Number: ______________________________

Did your PCP refer you to us ☐ Yes ☐ No If no, how did you hear about our office? ____________________________

Do you have an advanced care plan, surrogate decision maker or power of attorney? ☐ Yes ☐ No
If so, would you like to provide us with a copy of these forms? ☐ Yes ☐ No

Emergency Contact

Name: ____ Can we share health Information? ☐ Yes ☐ No
Address: ____
Relationship: _____________________ Phone (Home): __________________ Cell: ________________________

Insurance Information

Primary Insurance

Name of Insured: ____Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date _____________________Insured's Employer: ______________________________________

Insurance Company Name: ____

Insurance ID#:_____________________________ Group#: ____

Claims Address: ___________________________________ Provider Number: ___________________________

Patient's relationship to insured: ___________________Who is responsible for this bill? _________________

Secondary Insurance or ☐ No Other Coverage

Name of Insured: ____Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date _____________________Insured's Employer: ______________________________________

Insurance Company Name: ____

Insurance ID#:_____________________________ Group#: ____

Claims Address: ___________________________________ Provider Number:___________________________

Patient's relationship to insured: ___________________Who is responsible for this bill? _________________

CARITAS MEDICAL CENTER LLC

LEO O. OVADJE M.B.B.S. **JUN PARK M.D.**

Receipt of Notice of Privacy Practices Write Acknowledgement Form

I, ______________________, have been made available a copy of Caritas Medical Center's Notice of Privacy Practices.

____ ___________________________________

Patient Signature Date

Patient Portal

Please provide us with your email so that we can provide you with log in information to access your patient portal:

E-mail address is required: ____________________________________

(Your email address is only used for the patient portal)

YOU be in Control: go to **Caritasmed.com** and with your own personal login information you can request an *appointment, request refills for medication,* view your *lab results*, and *communicate* with your *doctor and nurses*.

Did you sustain an injury at work?

O Yes O No

Are your injuries accident related?

O Yes O No

Are you currently employed?

O Yes O No

Have you ever served in the military?

O Yes O No

Are you covered under an employer or union policy?

O Yes O No

Is your spouse or other family member employed?

O Yes O No

Do you have a secondary insurance policy?

O Yes O No

Are you covered under any other health care plan?

O Yes O No

Have you made any changes to your choice of Medicare options in the last open enrollment period?

O Yes O No O I am not a Medicare patient.

I am a new patient to this practice and am in a pre-existing provision with my insurance carrier.

O Yes O No

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Assignments of Benefits Form

I, ______________________________ (PATIENT'S NAME)**,** understand that services rendered to me by Caritas Medical Center are my financial responsibility and that the provider will bill my insurance company, _________________________ (CURRENT HEALTH INSURANCE COMPANY) as a courtesy. I authorize my insurance company to pay my benefits directly to Caritas Medical Center and I understand that I will be fully responsible for any outstanding balance on my account. *THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY*. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of all claims.

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Caritas Medical Center within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials. A photocopy of this Assignment shall be considered as effective and valid as the original.

______________________________ ______________________________
Patient or Guardian Witness

____
Date

CARITAS MEDICAL CENTER LLC

LEO O. OVADJE M.B.B.S. **JUN KI PARK M.D.**

HIPPA Privacy Authorization Form

Authorization

I authorize Caritas Medical Center to use and disclose the protected health information described below to: ____

List anyone you wish to have access to your medical information

Effective Period (Circle A or B)

a. This authorization for release of information covers the period of healthcare from:
____________________ to _____________________
Beginning Date *Ending Date*

b. All past, present, and future periods of treatment

Extent of Authorization (Please circle A or B and notate your choice)

a. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

b. I authorize the release of my complete health record with the exception of the following information:
   - Appointment Information
   - Medication Information
   - Lab/Test Results
   - Other (please specify):________________________________

1. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
2. This authorization shall be in force and effect until ___________________ (date or event), at which time this authorization expires.
3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

___________________________________ ___________________________________
Signature of Patient or Personal Representative Printed Name of Patient or Personal Representative

____
Date

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Financial Responsibility

Copayment: All office visits generally require a copayment or deductible per your insurance company. Exceptions may include when a patient has both primary and secondary insurance and the secondary insurance picks up both co-pays and deductible.

Deductible: A deductible is a portion of the bill that is the responsibility of the patient to pay before an insurance company will cover the service. It is the patient responsibility to know where they are with their benefits. Generally, a copayment is required for the visit in addition; some office visits require the patient to meet their deductible before the insurance pays benefits. If you have not met your deductible, you will be responsible for the full or partial payment, depending on your insurance contract. Please verify this information prior to scheduling your office visit, so you will know your estimated cost, if any.

No Show: Patients are given a scheduled time for appointment in this office. We do not accept walk –in appointments. A patient who fails to show up for their scheduled appointment or did not notify the office within 24 hours prior to the appointment shall be subject to a No Show penalty of $25.00 for follow up appointment. Please be advised that this No show payment is **NOT** covered by your insurance carrier or other payer and payment of missed visit must be paid prior to next scheduled appointment. A total of 3 successive **no shows** with **any** provider will prompt re-evaluation of your commitment to your care and could possibly result in dismissal from our practice.

Insurance coverage: I understand that it is my responsibility to keep current insurance information on file with this office. I further understand that every attempt to verify accurate insurance information will be performed by this office. Should it be determined that I was not eligible for coverage at the time of my office visit, I understand that I will be responsible for the payment of all services.

Referral Waiver: I understand that if my insurance carrier requires a referral in order for me to be seen by this office, it is my responsibility to obtain this referral. I further understand that every attempt will be made by this office to acquire a referral before my scheduled appointment and should it not be obtained after exhausting all means to obtain this referral, I agree to pay in full for all services rendered on that date of service at the self-pay rate.

Medication Refill Policy

Please allow 24-48 hours for medication refill and also note that we **DO NOT** refill medications on weekend.

_____________________________ _____________________________

Patient Signature Date