JAN J. SHIM,M.D.
4 East 88th St., New York, NY 10128

PATIENT REGISTRATION

Patients are to pay at time of service. If we participate in your plan, please sign the payment order below.

TODAY's DATE:_____ **PLEASE PRINT CLEARLY**

PATIENT NAME:_____ SOCIAL SECURITY #_____

PATIENT'S ADDRESS:_____ Zip _____

WORK #:_____ HOME #:_____ CELL #_____

DATE OF BIRTH:_____ EMAIL: _____

PATIENT: (Please circle) Male Female Married Single Divorced Widowed

Occupation:_____ Employer:_____

NATURE OF COMPLAINT (*if any*)_____

Please list all your medications:_____

ALLERGIES:_____

Primary Care Physician: _____ Who referred you to our office? _____

Preferred Pharmacy: _____ Telephone #: (_____) _____

In case of emergency please notify:_____ PH# _____

PRIMARY INSURANCE : _____ Plan Name:_____

Relationship to insured: (please circle) Self Child Spouse

Member #: _____ Group # *(if any)*_____

Name of Policy Holder: (other than patient)_____

SECONDARY INSURANCE :_____ Plan name:_____

Member #: _____ Group # *(if any)*_____

Name of Policy Holder:_____

I authorize my insurance company to pay Dr. Jan Shim all benefits due to me. This policy was in full force and in effect at the time of treatment. I am financially responsible for all balances remaining after the payment of possible insurance benefits and that, including deductibles, co-insurance, and copayment, should it become necessary, any and all reasonable collection/attorney fees will be added to the patient's bill. I permit a copy of this authorization to be used in place of the original.
I acknowledge that all payments are due at time of service for office consults, and ONE BUSINESS DAY prior to any procedure(s) needed. If non-payment exceeds 30 days, then all remaining balances will be referred to a collection agency.

Dr. Jan J. Shim has financial interest at Westside GI (619 W 54th St New York, NY 10019) and at Hudson Crossing Surgery Center (2 Executive Dr. Fortlee, NJ 07024).

Cancellation and Broken Appointment Policy
If an appointment is cancelled without 24 hours prior notice of which a patient does not show for an appointment, a $50.00 fee will be charged. With respect to subsequent cancellations or broken appointments, the patient will be seen at the doctor's convenience.

By signing below, I indicate that I have read, understand, and accept the statements and policies as outlined above.

X **LEGAL SIGNATURE**:_____DATE:_____

MEDICARE PATIENTS ONLY: I request that payment of authorized MEDICARE BENEFITS be made either to me or on my behalf to **Dr. Jan Shim** for services furnished to me by the provider. I authorize any holder of medical information about me to release to the HEALTH CARE FINANCING ADMINISTRATION and its agents any information needed to determine these benefits or the benefits payable for related services.

PATIENT SIGNATURE_____ DATE:_____

PATIENT HISTORY FORM

Date:

Last Name:	**First Name:**	**MI:**	**Date of Birth:**
Marital Status: Single Divorced Married Widow/ Widower			**Who Lives With You?**
Employer:	**Occupation:**		**What kind of work?**
Primary Care Physician:	**Other doctors involved with your care:**		

REVIEW OF SYSTEMS

Has the patient ever been diagnosed with any of the following? If yes, please check any that apply and explain in the space provided. Is your family physician aware of any symptoms/ illness that you have checked below? **YES NO**

SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES
Gastrointestinal			**Cardiac**			**Neurologic**			**Ear, Nose & Throat**		
Diarrhea			High blood pressure			Seizures			Loose Teeth		
Constipation			Low blood pressure			Weakness			Nosebleeds		
Rectal Bleeding			Irregular heartbeat			Migraines			Deafness		
Change in BM's			Chest pain			Previous stroke			**Psychosocial**		
Weight loss			**Respiratory**			**Musculoskeletal**			Substance Abuse		
Polyps			Asthma			Muscle Disease			Depression		
Irritable Bowel			Pneumonia			Arthritis			Anxiety disorders		
Crohn's Disease			Bronchitis			Neck pain			**Breast**		
Ulcerative Colitis			Chronic cough			Back pain			Lumps		
Trouble swallowing			Hoarseness			Blood Disorders			Cancer		
Nausea/ Vomiting			Tracheotomy			**Skin**					
Heartburn			**Genitourinary**			Rash			Please list below any symptoms/disease not listed above:		
Abdominal Pain			Kidney Disease			Bruises					
Hepatic			Frequent urine infection			**Ophthalmic**					
Liver Disease			**Endocrine/ Metabolic**			Cataracts					
Hepatitis			Diabetes			Glaucoma					
Pancreatitis			Thyroid Disorders			Blindness					

PAST HISTORY

Please explain any **YES** answers in detailed description in the box provided

Have you ever had any surgery or been Hospitalized? **YES NO** Have you had any problem with anesthesia? **YES NO** If YES, please list below:	**Surgeries**	**Dates**	**Hospitalizations other than surgery**	**Date**
Are you currently or have you ever used any Tobacco or alcohol products? **YES NO**	Alcohol: How many drinks? per day_____ per week_____ per month_____		Tobacco: How many packs per day? For how many years?_____ yr(s)_____	
Are you or have you ever used recreational/ illicit drugs? **YES NO**	If **YES** what kind?		For how long?	

Are you currently taking any medication or drugs (including over-the-counter, prescription, birth control pills)? **YES NO** Do you have any allergies (including, environmental, medication, food and reaction to previous blood transfusion? **YES NO** Explain:	**Medications**	**Dose**	**Times**	**Medications**	**Dose**	**Times**

FAMILY HISTORY: Please indicate if your parents brothers, sisters and/ or children have had any of the following conditions:

Condition	Relation to patient	Condition	Relation to patient	Condition	Relation to patient
Colon/ Rectal Cancer YES NO		Kidney problems YES NO		Heart disease YES NO	
Stomach Cancer YES NO		Ulcerative Colitis YES NO		Crohn's Disease YES NO	
Breast Cancer YES NO		Ovarian Cancer YES NO		Bleeding Problems YES NO	

Person Completing This Form/ Relationship to Patient: _____

Reviewed by Provider _____Date: _____

NOTICE OF PRIVACY PRACTICE

Effective Date: 10/24/2017

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We understand your medical information is private and we strive to protect the confidentiality of your medical records. The new federal regulations require that we issue this official notice of our practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that information. The practice is required to abide by the terms of the Notice of Privacy currently in effect and to provide notice of its legal duties and privacy practice with respect to the protected health information.

Prior to making important changes to our privacy practice, we will make available on request a revised Notice of Privacy Practices.

This notice will be followed by any health care professional authorized to enter information in your medical record. All employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates, site and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be used.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

For Treatment: We may use and disclose medical information about you to provide you with medical treatment or services. Example: In treating you for specific condition, we may need to know if you are allergic to specific drugs that could influence which medications we prescribe for the treatment purpose.

For Payment: We may use and disclose medical information about you so that treatment and services you receive from us may be billed and payment may be collected from your insurance, third party or you. Example: We may need to send your protected health information, such as your name, address, office visit date and codes identifying your diagnosis and treatment to your insurance company for payment.

Health Care Operations: We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures that Can Be Made Without Consent or Authorization

- As required during an investigation by Law enforcement agencies.
- To avert a serious threat to public health safety.
- As required by military command authorities for their medical records.
- To workers' compensation or similar programs for processing of claims.
- In response to legal proceeding.
- To a coroner or medical examiner for identification of body.
- If an inmate, to the correctional institution or law enforcement official.
- As required by the US Food and Drug Administration (FDA).
- Other healthcare providers treatment activities.
- Other covered entities= healthcare operations activities (to the extent permitted under HIPPA).
- Uses and disclosures required by law.
- Uses and disclosures in domestic violence or neglect situations.
- Health oversight activities.
- Other public activities.
- We may contact you to provide appointment reminders, information about treatment alternatives, or other health related benefits and services that may be of interest to you.

(Over)

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Jan J. Shim, M.D.
4 East 88th Street, Suite #1A
New York, NY 10128
Tel: (212) 535-5020

Patient's Name:_____ Date of Birth:_____

I understand that, under The Health Insurance Portability Accountability Act of 1996, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read and understood The Notice of Privacy Practices.

Dr. Jan Shim reserves the right to change the terms of the Notice of Privacy Practices. I understand the Practice will provide me with a copy of its Notice of Privacy Practices on request.

Patient's Signature:X _____ Date:_____.

I give permission to Dr. Shim and her staff to leave a message on my automated answering device or to family member regarding results of any test or appointments that were done in this office and/ or referred by this office.

X_____
(Signature of Patient, parent or guardian) (Date)

If a personal representative on behalf of the patient signs this consent, complete the following:

(Parent/ Guardian's Name) (Relationship) (Date)

JAN J. SHIM, M.D.

4 East 88th Street, Suite 1A. New York, NY 10128
Tel: (212) 535-5020 / Fax: (212) 360-7030 / www.drjanshim.com

Sign and complete this form to authorize Jan J. Shim, M.D., through its approved vendor to retain your debit/credit card information listed below.

By signing this form you give us permission to debit your account up to the amount of the patient's responsibility on or after the date your sign below in the event that your health insurance plan notifies us that payment for the provision of medical services by Dr. Jan Shim is your responsibility. Dr. Shim's office agrees to notify you prior to charging your credit card.

Please complete the information below:

In the event that my health insurance plan notifies Jan J. Shim, M.D. that I am responsible to pay for medical care rendered to me by Dr. Jan Shim, I hereby authorize Jan J. Shim, M.D. to charge my credit card account indicate for the amount that I am responsible.

_____

Print Name

_____ _____

Signature Date