GUILLERMO KOHN MD, LLC

7150 W 20th Ave. Suite 312, Hialeah, FL - 33016

PATIENT INFORMATION			
Patient Number	**Gender:**	**Date of Birth:**	
Last Name:		**Age:**	**Marital Status:**
First Name: **Initial:**			
Address:		**Home Phone:**	
City, State, Zip:		**Work Phone:**	
Email Address:		**Cell Phone:**	
Employer:			

RESPONSIBLE PARTY	
Account #	**Patient Relationship to Guarantor:**
Last Name:	**Gender:**
First Name:	**Date of Birth:**
Address:	**Home Phone:**
City, State, Zip:	**Work Phone:**
Employer:	**Cell Phone:**

INSURANCE INFORMATION	
Primary Insurance:	**Policy/Subscriber:**
Address:	**Date of Birth:**
City, State, Zip:	**Insured Policy ID:**
Plan Phone:	**Group Number:**
Effective Dates:	**Patient Relationship to Subscriber:**
Secondary Insurance:	**Policy/Subscriber:**
Address:	**Date of Birth:**
City, State, Zip:	**Insured Policy ID:**
Plan Phone:	**Group Number:**
Effective Dates:	**Patient Relationship to Subscriber:**

MISCELLANEOUS INFORMATION	EMERGENCY CONTACT INFORMATION
What is the best telephone number to contact you?	**Emergency Contact:** **Patient relationship to Contact:**
I authorize Guillermo Kohn, MD, LLC to leave a message containing detailed medical information at the number listed above. _____ *(Patient Initials)*	**Contact Home Phone:** **Contact Work Phone:** **Contact Cell Phone:**
Signature:	**Date:**

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Acct #: _____ Patient Name: _____ Date of Birth: _____

KNOWN ALLERGIES	
KNOWN MEDICATIONS	

What is your preferred Pharmacy's Phone number:	Who referred you to us? Please circle one:
( ) _____-_____	Friend Relative Physician Existing Patient Insurance Other (Please specify below) _____

MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION

INSURANCE AUTHORIZATION AND ASSIGNMENT. I hereby authorize Guillermo Kohn, MD, LLC to furnish information to my Insurance Carrier concerning illness and treatments and hereby Guillermo Kohn, MD, LLC payments for medical services rendered to Myself or dependents. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.**

Signature X_____ **Date:** _____

_____ _____

Patient's Signature Patient's Name

_____

Date

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CONSENT FOR TREATMENT, RELEASE OF INFORMATION AND FINANCIAL POLICIES

(Please read and review carefully, sign below)

I hereby authorize **GUILLERMO KOHN MD, LLC,** the use and/or disclosure of my Protect Health Information which specifically identifies me or which can reasonable be used to identify me to carry out my treatment, payment and healthcare operations.

Treatment includes but is not limited to: • The administration and performance of all treatment. • A medically indicated examination including but not limited to a pelvic exam • The administration of any needed anesthetics. • The use of prescribed medication. • The performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

Payment includes but is not limited to: The authorization of payment directly to **GUILLERMO KOHN MD, LLC**, of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance, however, you are responsible for your co-pay and or percentage which the insurance is not responsible for on the day of your visit.

- **IT IS THE PATIENT'S RESPONSIBILITY TO CONTACT THEIR INSURANCE COMPANY TO OBTAIN THE SCOPE OF COVERAGE OF ALL SERVICES NOT RENDERED OR BILLED BY THE OFFICE OF GUILLERMO KOHN MD, LLC.**
- **IT IS THE PATIENT'S RESPONSIBILITY TO OBTAIN ANY NECESSARY AUTHORIZATION OR REFERRAL FORMS FROM YOUR PRIMARY CARE PHYSICIAN WHEN REQUIRED. IF THE AUTHORIZATION OR REFERRAL IS NOT OBTAINED BEFORE THE VISIT, THE PATIENT IS LIABLE FOR PAYMENT IN FULL ON THE DATE OF SERVICE.**
  If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred.

I have fully read and understand the above payment policy. I agree to forward to **GUILLERMO KOHN MD, LLC**, all insurance or third party payments that I receive for services rendered to me immediately upon receipt.

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

• I assign the benefits payable for services to **GUILLERMO KOHN MD, LLC**. • I request this authorization also apply to all other insurance.
• I acknowledge that I have been given **GUILLERMO KOHN MD, LLC** Notice of Privacy Practices. • I understand that if I have questions or complaints that I should contact the Facility Privacy Official.

..../...../.....

Patient Signature Patient Date of Birth

...../...../.....

Today's Date

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AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION FROM OTHER HEALTHCARE FACILITIES

Patient Name: _____ SS#:_____

Telephone #: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Name of Healthcare Facility from which Records are Requested:

_____ Phone: _____ Fax:_____

(Please Print)

Address:_____ City:_____ State:_____ Zip:_____

Dates of Treatment Requested: _____ Reason for Disclosure: _____

MAIL INFORMATION TO:

Dr. Guillermo Köhn MD, FACOG FACS / GUILLERMO KOHN MD, LLC.
7150 W 20th Ave. Suite 312, Hialeah, FL-33016

FAX TO: **305-694-9881 - For questions contact our office number 305-694-9800**

I hereby authorize **Dr. Guillermo Köhn MD, FACOG FACS/ GUILLERMO KOHN MD, LLC,** to obtain the health information indicated below that is contained in my patient records to the Recipient named above. I understand and acknowledge that this may include treatment for physical and mental illness, genetic testing information, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes. The release of Psychotherapy Notes requires a separate authorization. Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record.

Check a Box ☑

	Complete Record		Radiology Reports
	Laboratory Reports		Pathology Reports
	Other (Specify)		

SPECIFIC AUTHORIZATIONS

The Following Information will not be released unless you specifically authorize it by marking the relevant box (es) below:

☐ Drug/ Alcohol Abuse or Treatment ☐ HIV/ AIDS Test Results or diagnoses ☐ Genetic Testing Information
☐ Psychotherapy Notes (The release of Psychotherapy Notes required a separate authorization)

This consent is subject to revocation at any time except to the extent the action has been taken thereon**.** Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, re-disclosure of your health care information by the Recipient may no longer be protected by law.

_____ Date Signed: _____/_____/_____

Signature of Patient or Legal Representative

Printed Name: _____ Relationship if not Patient: _____

If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18. **For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of the estate.

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PATIENT HEALTH QUESTIONNAIRE - DEPRESSION (PHQ-9)

(Please read carefully, fill the questionnaire and sign)

INSTRUCTIONS:
Over the last 2 weeks, how often have you been bothered by any of the following problems?

		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 FIDGETY 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 IN SOME WAY	**0**	**1**	**2**	**3**

.... /..... /.....
PATIENT SIGNATURE PATIENT DATE OF BIRTH

..... /..... /.....
DATE

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GENERAL CONSENT FOR COMPREHENSIVE EXAMINATIONS INVOLVING PELVIS AND/OR RECTUM

I understand the planned procedure and I consent to a medically indicated physical examination which may include, but may not be limited to the following:

(x) A female Gynecological Exam which may include a rectal exam and a pelvic exam

(x) An Ultrasound Exam which may include a probe placed in the vagina.

( ) A rectal exam only

( ) An Ultrasound Exam which may include a probe placed into the rectum.

( ) Other procedures as listed ____________________

( ) Examination of external genitalia___________________________

This examination will be performed by any provider from GUILLERMO KOHN MD, LLC.

The consent will remain active until I withdraw my consent in writing.

Name of Patient: _

____

Signature of Patient or Patient’s Representative if under 18

Date: ________________

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LATE CANCELLATION, NO CONFIRMATION, NO SHOW POLICY.

We understand that situations arise in which you must cancel your appointment. It is therefore your responsibility to cancel your appointment. You need to provide a notice, the latest 2 business days prior to the visit. The Doctor reserved his time for you that day. Each time a patient misses an appointment, another patient is prevented from receiving care. Therefore, IF NO CONFIRMATION, LATE CANCELLATION, NO SHOW AFTER CONFIRMATION. GUILLERMO KOHN MD, LLC reserves the right to cancel your appointment and a fee of $40 will apply.

This fee is not covered by insurance and must be paid prior to your next appointment.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

……

Printed Name /Signature

……

Date: