WILLIAM T. KLOPE, M.D.

PLEASE COMPLETE **ALL** THE SPACES BELOW. THE INFORMATION CONTAINED ON THIS FORM IS **STRICTLY CONFIDENTIAL. ALSO PLEASE BRING CORRECT INSURANCE CARD ALONG WITH ANY X-RAYS NEEDED FOR YOUR APPOINTMENT AND YOUR FULL COPAY AMOUNT. FOR YOUR PROTECTION WE WILL REQUEST AND COPY A STATE OR GOVERNMENT PHOTO ID IN ORDER TO VERIFY YOUR IDENTITY. YOU MAY NOT BE SEEN WITHOUT YOUR ID. (FOR MINORS WE WILL NEED PARENT OR GUARDIAN PHOTO ID).**

DATE__________

NAME (LAST) ______________________ (FIRST)______________________(M.I.)____DOB__________

ADDRESS____

CITY____________________________ STATE_____________________ ZIP CODE__________

HOME PHONE (_____)_____________________ WORK PHONE (_____)_____________________

CELL # (_____)__________________ DRIVERS LICENSE #____________________STATE________

SOCIAL SECURITY #______________________________ OR LAST 4 #'S________________

EMAIL ADDRESS____

EMPLOYER NAME____

EMPLOYER ADDRESS____

CITY__________________________ STATE_________________________ ZIP CODE__________

SEX: M_____ F_____ MARITAL STATUS: M____ S____ STUDENT: Y____ N____ AGE__________

EMERGENCY CONTACT____________________________PHONE NUMBER________________

RELATIONSHIP TO YOU____

PERSON RESPONSIBLE FOR ANY BALANCE DUE______________________________________

ADVANCE DIRECTIVE: YES______ NO______ IF YES, PLEASE BRING COPY WITH YOU TO YOUR APPOINTMENT (CAN RECEIVE INFORMATION AT CARINGINFO.ORG)

PATIENT PHARMACY & LOCATION____

PRIMARY INSURANCE COMPANY:

POLICY ID #______________________________ POLICY GROUP #______________________

POLICY HOLDER'S NAME______________________________________DOB______________

RELATIONSHIP______________________________

SECONDARY INSURANC COMPANY:

POLICY ID #______________________________ POLICY GROUP #______________________

POLICY HOLDER'S NAME______________________________________ DOB______________

RELATIONSHIP______________________________

PRIMARY CARE PHYSICIAN ______________________________ TELE#______________________

REFERRING PHYSICIAN______________________________TELE#______________________

I AUTHORIZE **ALL** MY TELEPHONE NUMBERS TO BE USED TO CONTACT ME FOR **ALL MEDICAL OR COLLETION PURPOSES.** YES_____ NO_____

SIGNATURE______________________________________

WILLIAM T. KLOPE, M.D., INC.

BECAUSE THIS OFFICE IS CONCERNED ABOUT YOUR PRIVACY PROTECTION WE ASK THAT YOU PLEASE READ AND SIGN THE FOLLOWING IN ORDER FOR OUR OFFICE TO REMAIN COMPLIANT WITH THE HIPPA PRIVACY STANDARD LAWS.

....

I GIVE MY PERMISSION TO RELEASE MEDICAL RECORDS **PERTAINING TO MY TREATMENT** *WITH DR. KLOPE TO PHYSICIANS THAT MAY REQUEST THEM DURING THE TIME THAT I AM UNDER DR. KLOPE'S CARE. YES_____ NO_____*

WE ALSO ASK THAT YOU PLEASE KEEP YOUR SCHEDULED APPOINTMENTS. THERE WILL BE A $25.00 CHARGE FOR ANY FOLLOW UP APPOINTMENT YOU FAIL TO KEEP WITHOUT A 24 HOUR NOTICE GIVEN PRIOR TO THAT APPOINTMENT. NO SHOW FEES FOR VASECTOMIES ARE $100.00 AND $50.00 FOR ANY OTHER PROCEDURES. (ALL NO SHOW FEES WILL BE COLLECTED PRIOR TO NEXT VISIT WITH DR. KLOPE.)

....

WHEN IT BECOMES NECESSARY TO CONTACT YOU BY PHONE, PLEASE LIST THE NUMBER(S)WHERE YOU'D LIKE US TO CALL YOU. 1ST#__________________ 2ND#__________________MAY WE LEAVE MESSAGES, SUCH AS LAB RESULTS OR OTHER MEDICAL INFORMATION ON AN ANSWERING MACHINE ,OR WITH ANOTHER PERSON WHO ANSWERS THE PHONE AT LISTED NUMBERS? YES______NO______. MAY WE CONFIRM APPTS. AT LISTED NUMBERS? YES______ NO_______

....

I HAVE BEEN INFORMED OF THE PRIVACY PRACTICES ACT AND IT HAS BEEN MADE AVAILABLE FOR ME TO READ AND REVIEW. I ALSO UNDERSTAND THE OFFICE POLICY FOR ALL NO SHOW FEES.

*SIGNATURE*______________________________________*DATE*_____________

*PRINT NAME*______________________________________

PLEASE BE CONSIDERATE AND CALL IN ADVANCE IF YOU ARE UNABLE TO MAKE YOUR SCHEDULED APPOINTMENS.

THANK-YOU

William T. Klope, M.D.

FINANCIAL POLICY & CREDIT CARD POLICY

All patient responsibility amounts, **including, deductibles, co-payments, and patient percentages are due at the time of service. (This also includes any amounts due prior to surgery).** It is our office policy to keep a credit card on file for all our patients (other than HMO patients without deductibles). If there is a remaining balance once your claim has been processed, you credit card will be charged after a courtesy call.

As a courtesy, our office will call and bill your insurance company to obtain benefits information. This is not a guarantee that your insurance company will pay. It is your responsibility to understand your insurance and its benefits. Patients are financially responsible for all fees not paid for by their insurance company (for any reasons). PLEASE KNOW AND UNDERSTAND YOUR BENEFITS AT YOUR TIME OF SERVCE. It is not the responsibility of our staff to know your benefits.

Patients covered by **Medicare only** will be expected to pay their 20% portion at the time of their appointment or we can use their credit card on file. **Medicare's 2018 deductible is $183.00** and will need to be met before Medicare will pay your claims. **WE ARE NOT MEDI-CAL PROVIDERS, SO IF YOU HAVE MEDI-CAL YOU WOULD ALSO BE RESPONSIBLE FOR MEDICARE'S 20% COINSURANCE** Initial:________

This office accepts payments in the form of cash, MasterCard/Visa, debit cards, and checks. **There will be a $30.00 charge on all returned checks.**

Again, we will do our best to call and check on your eligibility and benefits, but ultimately it is the **responsibility of the patient** to understand their own eligibility and benefits at the time of the service. **There is NO GUARANTEE of payment on any claim until it is processed.**

*******SO PLEASE KNOW AND UNDERSTAND YOUR OWN INSURANCE*******

We ask that if we do have to send you a statement, that you pay your balance on that first statement. There will be a monthly $5.00 re-bill charge on all balances that need to be billed again (unless payment arrangement has been made). There is also a 1.5% interest rate on all patient account balances past 30 days. Thank you for you cooperation and understanding.

I have read and understand the **Financial and Credit Card Policies** for the office of William T. Klope, M.D.

Patient Signature:______________________________ Date:______________

William T. Klope, M.D.

Assignment of Benefits

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to the office of William Klope, M.D. for any charges not covered by my health care benefits. It is my responsibility to notify the office of William Klope, M.D. of any changes in my health care coverage. In some cases exact insurance benefits can not be determined until the insurance company receives the actual claim. I realize that I am fully responsible for any claim or portion of claim that is not paid. I understand that by signing this form that I am accepting financial responsibility as explained above for all payments due for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to William Klope, M.D. for all covered medical services and/or supplies provided to me during all courses of my treatment and care with him. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by William T. Klope, M.D. and will constitute a continuing authorization, maintained on file at his office, which will authorize and allow for direct payment to William T. Klope, M.D. of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies, and/or care provided to me by William T. Klope, M.D.

Authorization to Release Information

I authorize the release of any medical or any other information to the health care financing administration, my insurance carriers, or other entity necessary to determine insurance benefits payable for related medical services and/or supplies provided to me by William T. Klope, M.D. A copy of this authorization will be sent to the health care financing administration, my insurance carrier, or other medical entity, if requested. The original authorization will be kept on file by the office of William T. Klope, M.D.

____

Patient/Insured (printed name)

____

Patient/Insured (signature)

____

Date of Signature

William T. Klope, M.D.

Patient's Name ______________________________________Date________________

To all patients:
We are asking the following questions in order to keep our records compliant with the Medicare Electronic Health Record Initiative Program. You will only need to complete this form once. Thank you!

GENDER
_____Male
_____Female

PREFERRED LANGUAGE
Please indicate your preferred language:
_____English
_____Spanish
_____American Sign Language
_____Chinese Languages
_____French
_____German
_____Tagalog
_____Vietnamese
_____Italian
_____Korean
_____Russian
_____Polish
_____Arabic
_____Portuguese
_____Japanese
_____French Creole
_____Greek
_____Hindi
_____Persian
_____Urdu
_____Gujarati
_____Armenian
_____Hawaiian
_____Declined to Specify

RACE
Please indicate your race:
_____American Indian or Alaskan
_____Asian
_____African American
_____Caucasian
_____Hispanic
_____Native Hawaiian or other
_____Unknown
_____Declined to Specify

ENTHNICITY
Please indicate your ethnicity:
_____Hispanic Origin
_____Not of Hispanic Origin
_____Declined to Specify

Dr. William Klope
History and Physical

Patient Name: ______________________________ **Date:**__________

ALLERGIES to medications, *and* the REACTION or side effect you get from it:

____
____
____

SOCIAL HISTORY

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐
If you have children, how many children do you have? ______
Occupation (or prior occupation)? ______________________________ Retired? ☐
Do you have unsafe sex? Yes ☐ No ☐
Do you exercise regularly? Yes ☐ No☐

SUBSTANCES: Check (√) whether current or past use of the following substances.

Substance	Never	Current	Past	Amount Per Day
Caffeine				
Tobacco				
Alcohol				
Street Drugs				

PATIENT MEDICAL HISTORY

Do you now, or have you ever had, the following conditions?

☐ Cardiovascular Disease (ASCVD)
☐ Hypertension (HTN)
☐ History Heart Attacks (MI)
☐ Hypercholesterolemia (High Cholesterol)
☐ Urinary Tract Infection (UTI)
☐ Elevated PSA
☐ Testicular Problems
☐ Hematuria (Blood in Urine)
☐ Kidney Stones
☐ Diabetes

☐ Kidney Disease
☐ Cancer
If yes, what type? ____________________
☐ STD
If yes, what type? ____________________
☐ Infertility
☐ Prostate
☐ Surgery (please list)
____
____
____
____

FAMILY MEDICAL HISTORY

Does anyone *in your family* have the following? *Specify relationship* and *age* at time of problem

Hypertension Yes ☐ No ☐
Heart Problems Yes ☐ No ☐
Kidney Problems Yes ☐ No ☐
Bladder Problems Yes ☐ No ☐
Blood clots in legs or lungs Yes ☐ No ☐
Bleeding/Clotting Disorders Yes ☐ No ☐
Is your mother alive? Yes ☐ No ☐
Is your father alive? Yes ☐ No ☐

Kidney Stones Yes ☐ No ☐
Diabetes Yes ☐ No ☐
Stroke Yes ☐ No ☐
Prostate Problems Yes ☐ No ☐
Cancer Yes ☐ No ☐ Type:_________
Other____________________

MEDICATIONS you are currently using (Please bring ALL medications on day of Consultation)

____

____

____

____

WHY ARE YOU HERE TODAY?

____

____

OTHER CURRENT MEDICAL PROBLEMS?

____

____

____

SYMPTOMS

Circle any *persistent* symptoms you currently have or have has in the PAST YEAR.

RESPIRATORY

Bronchitis
Emphysema
Asthma
Shortness of Breath

GASTROINTESTINAL

Haital Hernia
Ulcers
Colitis
Abdominal Pain
Blood in Stool

CONSTITUTIONAL SYSTEMS:

Fever
Chills
Weight Loss
Appetite Change
Headache
Cancer
Depression

UROLOGICAL

Kidney Stones
Slow Stream
Bedwetting
Inability to Pass Urine
Urinary Tract Infection
Blood in Urine
Trouble Emptying Bladder
Are you having pain? Where?

CARDIOVASCULAR

Arrhythmia
Irregular Pulse
Heart Murmur
Valve Disease
High Blood Pressure
Heart Attack
Angina
Phlebitis
Circulatory Problems
Rheumatic Fever

ENDOCRINE

Thyroid Disease
Diabetes
Pituitary Disease

MUSCUOSKELETEAL

Osteoporosis
Join Pain
Fractures
Gout

SKIN

Shingles
Rashes/Hives

NEUROLOGICAL

Seizures
Stroke
Parkinson's Disease

NEPHROLOGICAL

Renal Disease
Nephritis

HEMATOLOGICAL

Hepatitis/Jaundice
Bleeding Tendency
Swollen Glands
HIV (AIDS)

FEMALES:

Number of Pregnancies:
Last Menstrual Period: