ANANDA MEDICAL

Kumari A. Hobbs MD, MSCR, FACOG

P: (212) 344-9524
F: (212) 547-8755
W: kumarihobbsmd.com
A: 40 E 10th St, Suite 1W, New York, NY 10003

HIPAA

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ MI _____
DATE OF BIRTH _____ SSN _____
STREET _____ APT/STE _____ CITY _____
STATE _____ ZIP _____ CELL PHONE _____
EMAIL _____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

EMPLOYER

Name: _____
Address: _____
City, State Zip: _____
Occupation: _____
Phone: _____

EMERGENCY CONTACT

Name: _____
Relationship: _____
Phone: _____
May we share personal medical information? ☐ Yes ☐ No

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the provider or clinic. I authorize my provider to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of medical care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

I, acknowledge and agree that I have received a copy of KUMARI ANANDA HOBBS MD PC's Notice of Privacy Practices under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

_____ _____ _____

Patient / Guardian Signature *(If guardian, write name please)* Date

FOR OFFICE USE ONLY:

KUMARI ANANDA HOBBS MD PC made the following good faith efforts to obtain the above-referenced individual's written acknowledgment of receipt of the Notice of Privacy Practices, but was unsuccessful in obtaining the individual's acknowledgment.

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CREDIT CARD PAYMENT AUTHORIZATION

PATIENT NAME: _____ DOB: _____

Patients are responsible for all charges and services that are not covered by their insurance provider. In accordance with our office's payment policies, we ask that you review the following terms and conditions and provide an alternative payment method.

1. I understand that the Provider will submit billing claims to my insurance provider for reimbursement, but I am solely responsible for all charges and services I receive from this Provider, including those covered by my insurance.
2. I understand that payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider.
3. I understand that I may be charged a service fee or service may be denied for failure to pay a co-pay or any outstanding balance at the time of service.
4. I understand that it is my responsibility to ensure that the Provider has current information on file, at all times, including my address, contact details, insurance information, and a valid credit/debit card or other payment information.
5. I understand that my signature and payment information will be held on file for future use by the Provider.
6. I understand that the Provider may offer an automated payment plan option, if available, and that this convenience may incur interest charges.
7. I authorize the above practice and/or its designated payment agent to apply charges to my payment card and/or bank account for all amounts owed to the practice for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) co-payments, (iii) co-insurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.
8. I understand that I may receive a monthly statement for any outstanding balance that is not satisfied by a charge to my payment method and that I am responsible for paying this balance by its due date.
9. I understand that unpaid balances may incur additional fees and interest charges.
10. I understand that I may not be provided with advance notice of authorized payments and any advance notice that is given is done so as a courtesy of the provider. Transactions will be maintained in patient file.
11. I authorize the Provider and/or its designated payment agent to send electronic account statements, invoices, and receipts to the email address I have provided to this office. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.
12. I understand this authorization will remain in effect until the expiration of the credit card or until I provide a 30-day written notice of cancellation to the Provider.

ACKNOWLEDGMENT AND AUTHORIZATION:

By signing this form (i) I acknowledge that I have received, reviewed, and understand the Provider's payment policies, (ii) I authorize the Provider and/or its designated payment agent to charge my credit/debit card in accordance with the payment policy, and (iii) I certify that I am an authorized cardholder or user of this credit/debit card.

Name on Card: _____ Email Address: _____

Credit Card # _____ CVV: _____ Billing Zip Code: _____

Exp. Date (MM/YYYY): _____

_____
Cardholder's Name Printed

_____ _____
Cardholder's Signature Date

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New Patient Intake Form

Name: _____ Preferred Name _____ Preferred Pronoun(i.e. she/he; her/him) _____

Date of Birth: _____ Who referred you? _____

Reason for visit: _____

Sexuality/Gender Identity

What is your sexual orientation?
☐Straight/Heterosexual
☐Lesbian/Gay
☐Bisexual
☐Other _____
☐Decline to state

What sex were you assigned at birth?
☐Female
☐Male
☐Decline to state

What is your gender identity?
☐Female
☐Transgender woman/Transwoman
☐Male
☐Transgender man/Transman
☐Gender queer/Gender non -conforming
☐Decline to state

Recent Exam

Type of exam	Date of last exam	Location of exam
Pap test		
Mammogram		
Colonoscopy		
Pelvic/Transvaginal ultrasound		
Bone density study		

Gynecologic History

Date of last menstrual period: _____

Age (years) at 1st period _____; My period usually occurs every_____ days and lasts for _____days; Age at Menopause_____

Do you have a history of (If yes please provide date and describe):

☐ Ovarian cysts _____
☐ Fibroids _____
☐ Abnormal Pap test _____
☐ Sexually Transmitted Infection _____

Have you ever used oral contraceptives (if so for how many years)? _____

Have you ever used hormone replacement therapy (if so for how many years)? _____

Are you sexually active? ☐ No ☐ Yes Any problems? _____

Total number of pregnancies _____

# of Vaginal deliveries ___; Cesarean sections ___; Miscarriages ___; Abortions ___; Ectopic pregnancies ___;

Pregnancy Complications_____

Current Medications (include vitamins, herbs and other supplements)

Please review your attached medication list. Please add/remove medications based on what you currently take.

Name of Medication	Dosage	How Often

Allergies

Are you allergic to any medications? ☐ No ☐ Yes (Please specify the medication and reaction):

Name: _____

Medical History (either now or in the past/detail below with year of diagnosis and treatment given)

☐ Asthma
☐ Cancer
☐ Cardiac disease
☐ Diabetes
☐ Hypertension / high blood pressure
☐ Hyperlipidemia / cholesterol
☐ Irritable bowel syndrome
☐ Inflammatory bowel disease
☐ Lupus
☐ Osteoporosis / osteopenia
☐ Stroke
☐ Thrombotic disorder (blood clots)
☐ Thyroid disease (low / high)
☐ Reflux (GERD)

Psychiatric diagnosis
☐ Anxiety
☐ Depression
☐ Bipolar disorder
☐ Other: _____
_____
_____

Surgical History

Name of Procedure	Date of Procedure	Reason for Procedure

Family History

Do you have a family member with any of the following cancers (if yes please list which family member and age of diagnosis)

☐ Breast cancer _____
☐ Ovarian cancer _____
☐ Uterine/endometrial cancer _____
☐ Prostate cancer _____
☐ Pancreatic cancer _____
☐ Colon cancer _____
☐ Melanoma _____
☐ Other cancer (specify) _____

Mother: ☐ Living ☐ Deceased (cause) _____

Father: ☐ Living ☐ Deceased (cause) _____

Siblings: Number living: _____ Number deceased: _____ Cause: _____

Social History

Do you exercise? If so what do you do _____

Occupation_____ Marital Status_____

Do you smoke? _____ How many packs a day? _____ If you quit, when was this? _____

Do you drink alcohol? _____ How many drinks per week? _____ Any other drugs? _____ Which other drugs?_ _____

Review of Systems: Are you experiencing any of the following symptoms?

Constitutional	☐ No	☐ Weight loss	☐ Weight gain	☐ Fever	☐ Fatigue
Eye Problems	☐ No	☐ Vision Changes	☐ Glasses	☐ Contacts	☐ Other
Ear, Nose, Throat	☐ No	☐ Ulcers	☐ Sinusitis	☐ Headache	☐ Hearing Problems
Cardiovascular	☐ No	☐ Chest pain	☐ Leg Swelling	☐ Palpitations	☐ Other
Respiratory	☐ No	☐ Wheezing	☐ Cough	☐ Shortness of Breath	☐ Other
Gastrointestinal	☐ No	☐ Diarrhea	☐ Constipation	☐ Nausea	☐ Vomiting
Urinary	☐ No	☐ Painful Urination	☐ Urgency	☐ Frequency	☐ Bloody Urine
Skin/Breast	☐ No	☐ Breast Pain	☐ Nipple discharge	☐ Breast Mass	☐ Skin Rash
Neurological	☐ No	☐ Fainting	☐ Seizures	☐ Numbness	☐ Trouble Walking
Psychiatric	☐ No	☐ Depression	☐ Anxiety	☐ Other	
Blood/Lymph	☐ No	☐ Easy Bruising	☐ Abnormal Bleeding	☐ Swollen Glands	☐ Other
Musculoskeletal	☐ No	☐ Weakness	☐ Pain	☐ Other	

PHYSICIANS

Medical / primary care physician: _____ Phone #_____

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PATIENT CONSENT TO TREATMENT

Welcome to Kumari Ananda Hobbs MD PC. We are committed to providing you with the best possible care and are pleased to explain our professional fees to you at any time. Your clear understanding of our Patient Consent to Treatment is important to our professional responsibility.

By signing this Patient Consent to Treatment, you give your consent to receive the medical services from Kumari Ananda Hobbs MD PC. Professional care may include, but is not limited to, review of any information you have provided or questions you have answered prior to an examination, an examination and/or consultation, prescription of medication and provision of any follow-up treatment, as needed.

You understand that there are risks and benefits when receiving health care services generally. You acknowledge that your medical treatment and its risks and benefits, as well as the potential consequences of not receiving the recommended treatment, have been explained to you. You acknowledge that you have had the opportunity to ask questions about your care and its risks and benefits. Any questions you had have been answered to your satisfaction. You acknowledge that no guarantees have been made to you regarding the result of your medical care.

_____

Patient Name

_____ _____

Patient / Guardian Signature Date

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ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Welcome to Kumari Ananda Hobbs MD PC. We are committed to providing you with the best possible care and are pleased to explain our professional fees to you at any time. Your clear understanding of our Acknowledgement of Financial Responsibility is important to our professional responsibility. Please ask if you have any questions about our fees, our financial policy, or your financial responsibility.

You understand that you are financially responsible for the charges for the services rendered to me by my provider. If your health insurance covers your treatment, your provider will submit insurance claims and accept payments from your insurance company. You authorize assignment of your insurance benefits to be paid directly to your provider for any services rendered as allowable under standard insurance and other third-party payor contracts. You understand you are financially responsible for charges not covered by this assignment. If you receive payment from your insurance plan for benefits due to your provider for your care, other than as reimbursement for payments you have already made, you agree to promptly sign the payment to my provider, or pay that amount to your provider directly.

If your insurance fails to pay the estimated benefit for any reason, you understand that those unpaid amounts remain your responsibility. You assume full financial responsibility and agree to pay for all charges not covered or paid for by your insurance including, but not limited to, co-payments, co-insurance and/or deductibles and expenses of every kind and description. You understand that co-pays are expected at the time of service. You understand that if your provider does not participate with your health care plan, payments for any co-insurance, deductible and non-covered amount is expected at the time of service unless prior arrangements have been made.

You understand that you are personally responsible to pay for care received from my provider if you do not have insurance or your insurance does not pay for your care because:

• Your health plan requires you to obtain a written referral before your provider treats you and you did not get a referral;

• Your health plan denies payment for these services and leaves you responsible for payment;

• Your health plan decides that services you received are not medically necessary and/or not covered by your insurance plan;

• Your health plan coverage has lapsed or expired at the time you receive services; or

• You have chosen not to use your health plan coverage. You understand that if you are a self-pay patient, payment is expected at the time of service unless prior arrangements have been made.

You acknowledge and agree that if you fail to pay any balance, you will be responsible for any expenses incurred in connection with securing payment, including, but not limited to, all court costs, reasonable attorneys' fees, and all other reasonable collection expenses.

If you do not attend a scheduled appointment or cancel an appointment with less than twenty-four (24) hours' notice, you will be charged a cancellation fee in the amount of $150.00. For more information on cancellation fees, your provider's cancellation policy is available upon request.

_____

Patient Name

_____ _____

Patient / Guardian Signature Date

Healthix

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow KUMARI ANANDA HOBBS MD PC to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically to improve the quality of healthcare and meets the privacy and security standards of HIPAA, the requirements of the federal confidentiality laws, 42 CFR Part2, and New York State Law. To learn more visit Healthix's website at www.healthix.org.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for KUMARI ANANDA HOBBS MD PC to access ALL of my electronic health information through Healthix to provide health care.

☐ **2. I DENY CONSENT** for KUMARI ANANDA HOBBS MD PC to access my electronic health information through Healthix for any purpose.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

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HIV-SPECIFIC MODEL CONSENT FORM
Informed Consent to Perform HIV Testing

My health care provider has answered any questions I have about HIV/ AIDS. I have been provided information with the following details about HIV testing:

- HIV is the virus that causes AIDS and can be transmitted through unprotected sex (vaginal, anal, or oral sex) with someone who has HIV; contact with blood as in sharing needles (piercing, tattooing, drug equipment including needles), by HIV-infected pregnant women to their infants during pregnancy or delivery, or while breast feeding.
- There are treatments for HIV/AIDS that can help an individual stay healthy.
- Individuals with HIV/AIDS can adopt safe practices to protect uninfected and infected people in their lives from becoming infected or being infected themselves with different strains of HIV.
- Testing is voluntary and can be done anonymously at a public testing center.
- The law protects the confidentiality of HIV test results and other related information.
- The law prohibits discrimination based on an individual's HIV status and services are available to help with such consequences.
- The law allows an individual's informed consent for HIV related testing to be valid for such testing until such consent is revoked by the subject of the HIV test or expires by its terms.
- I agree to be tested for HIV infection. If the results show I have HIV, I agree to additional testing which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs.

I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time. If I test positive for HIV infection, I understand that my health care provider will talk with me about telling my sex or needle-sharing partners of possible exposure.

I may revoke my consent orally or in writing at any time. As long as this consent is in force, my provider may conduct additional tests without asking me to sign another consent form. In those cases, my provider will tell me if other HIV tests will be performed and will note this in my medical record.

Patient Name or Surrogate_____ Date _____

Signature (Patient or Person Authorized to Consent) _____