Tips for Success for New Patients

Dear Patient,

Welcome to Doctor Kara, PC and getting the health care you deserve. I have put together this New Patient Packet so you can be successful in and enjoy your relationship with Doctor Kara, PC. These tips for success will help you get the attention and care you deserve. To make sure everyone gets exceptional customer service, we do things very differently, so a bit of instruction will help you get off to a great start!

Your packet contains all the materials you need to get started:

1. a consent to treat form
2. a medical history form
3. a controlled substance agreement (required of every patient)
4. an appointment and billing policy acknowledgement form
5. A patient checklist of symptoms
6. a request for past medical records (required if you are asking for the following medications for pre-existing illnesses: sleeping pills, anxiety pills, ADHD drugs, pain pills)

You will need to complete the entire packet before your visit, since your appointment time does NOT include time for paperwork.

You will also need to bring the following to your appointment:

1. Driver's License
2. Insurance Card (if you are insured)

Accepted forms of payment: Visa, Mastercard, Discover, and cash.

SPECIAL NOTE: Beginning June 1, 2012 we have a new medical record system that will allow you to complete the MEDICAL HISTORY FORM online. If you complete this form online at www.doctorkara.com under the patient portal tab, it will decrease the amount of time you spend in our waiting room while your new chart is put together by our receptionist. You are welcome to give us your medical information earlier since Dr. Kara will review it before your appointment. You still need to bring the other medical forms to your appointment.

PATIENT INFORMATION

Patient's Name (Last, First, Middle):		Marital status: Single Married Divorced Separated Widowed Partnered
Social Security #:	Age:	
Birth Date:	Sex: ❑ M ❑ F	
Street Address:		
City, State, Zip Code:	Home Phone: ( )	Cell Phone : ( )
Employer:	Employer phone no.: ( ) -	
How did you find Doctor Kara, P.C.?:		
Email Address for appointment reminder notices and medical updates (required):		

REQUIRED FINANCIAL AND PAYMENT INFORMATION

Debit/Credit Card Number (16 digits) : Required Information MC VISA Discover Expiry date (MM/YY):	
Printed Name of Authorized Cardholder:	Issuing Bank:
Billing Address for the Credit Card: ❑ Same as Above	
Do you have insurance? ❑ Yes ❑ No	Copy of Card Obtained: ❑ Yes ❑ No Copy of Driver's License: ❑ Yes ❑ No
Name of Insurance Company:	Group ID Number:
Insured's Birth date (MM-DD-YYYY):	Insured's Social Security Number:

Patient's relationship to Insurance Holder:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name and address of local friend or relative (not living at same address):	
Home phone: ( )	Work Phone: ( )

BILLING POLICY OF DOCTOR KARA, P.C.

In the rare event that payments or co-payments are not paid in full at the time of service for any reason, the following charges will apply to your account:

1. **All insured patients are responsible for: (a) all co-pays and payments toward unmet deductibles, (b) any administrative fees and all medical charges regardless of decisions made by my insurance plan. Due to the nature of submitting claims to insurance plans and delays in payment, any finance charge and invoicing fee will be retroactive to the date of service.**
2. Insured patients are responsible for providing accurate insurance information *at the time of service, including proof of insurance coverage*. Any insured patient who fails to provide an insurance card will be treated as a cash pay patient and is subject to cash pay rates at the time services are rendered. If you submit a valid card after you have been processed as a cash pay patient, you will incur a $25 fee for reversing previous bookkeeping entries.
3. Invoicing fee: $10.00 per invoice to cover postage and time spent generating a paper invoice. Electronic invoicing is free of charge. You must provide valid email address to qualify for electronic invoicing. Any failure to respond to an electronic invoice will trigger a default to paper invoicing.
4. The annual finance charge of 18% will be applied to the unpaid account balance (1.5% per month).
5. Once the unpaid account balance reaches 30 days maturation from the date of service, the account will be turned over to small claims or a collection agency, unless special arrangements have been made with Doctor Kara PC for installment payments on overdue balances.
6. In the event legal action is taken to collect on the account, an additional amount of 50% of the principal balance will be added to offset the costs of attorney's fees, court costs, or collection agency actions. This additional amount is in recognition of the costs associated with collection processing.
7. In the event Doctor Kara, P.C. is unable to obtain a valid payment I agree to pay an additional administrative fee of $15.00 per occurrence to offset the time and effort spent in notifying me of an invalid payment.
8. All communication and inquiries to Doctor Kara, P.C. about my account must be submitted in writing by the account holder (or executor of the estate in cases of a deceased account holder). Doctor Kara, P.C. will respond in writing within 7 calendar days, except during periods of extended absence. Office closure dates will be posted on the clinic website and the office entrance. I agree to notify the office in writing of any changes in my contact information (name, address, phone number, work number, etc). I hold Doctor Kara, P.C. blameless for lost communication in the event I fail to maintain accurate contact information with the office.
9. The information given in the registration form is valid and true to the best of my knowledge. I understand I am financially responsible for all office charges payable to Doctor Kara, PC. I also authorize Doctor Kara PC to release limited medical information to expedite the process of requesting lab or diagnostic tests and necessary medical referrals to other medical professionals during the course of my treatment.

Patient Signature: _____ Date: _____

APPOINTMENT POLICY OF DOCTOR KARA, P.C.

We realize that life is full of unexpected events that can cause a patient to be unable to meet a previous obligation. We ask that you make every attempt to let us know something has gone awry. We are committed to every patient having the opportunity to enjoy the unique and exceptional customer service we offer: self scheduling, on-time appointments, and "No Wait" guarantee. These policies help protect our great customer service and patient pricing:

1. Tardiness Clause:

- I understand I may only be seen for the remaining time of the appointment and may have to schedule a second visit to complete any unfinished business.
- I understand I will be responsible for the cash-pay rate of $4/minute for the tardiness and the missed service that may not be paid by insurance, if insurance applies to my case.
- I understand I may be asked to reschedule for another appointment if tardy by 10 minutes or more. Our office clock is used as the official clock, as it is an atomic clock.

2. Appointment Fees:
   - I understand that I will be charged $1 by credit card for my appointment reservation. If I request a rescheduling, the fee is $25. Failure to show for an appointment or cancelling less than 3 ***business*** days in advance will result in a charge for the full appointment. The charge is based on the cash pay rate for the length of your appointment. The appointment fee offsets the financial loss incurred to Doctor Kara, PC since appointments are not double or triple-booked.
3. Cancellations and rescheduling should handled by calling Doctor Kara, P.C. at 801-495-9303.

Patient Signature: _____ Date: _____

FINANCIAL VERIFICATION STATEMENT

My signature verifies I understand and validate the following statements:

- I am the authorized cardholder of the credit card listed on the registration page 1.
- I designate the credit card listed on page 1 as the "credit card of record" for my account, unless I have made other arrangements with Doctor Kara PC.
- In the event the credit card of record is reported as lost or stolen, I will provide Doctor Kara, P.C. with new and valid credit card information as the credit card of record to maintain an account in good standing.
- I authorize Doctor Kara, P.C. to make charges against the credit card of record in accordance to the terms and conditions listed in the billing policy, appointment policy, or any other special contracts I hold with Doctor Kara, P.C. (i.e. VIP membership).
- I am responsible for maintaining accurate and valid payment information with Doctor Kara, P.C. to facilitate valid payment for medical services requested and/or received.
- In the event Doctor Kara, P.C. is unable to obtain a valid payment, using the credit card of record, I agree to pay an additional administrative fee of $15.00 per occurrence to offset the time and effort spent in notifying me of an invalid payment.
- Future terms and conditions may change without prior written notice and will be posted on the Doctor Kara, P.C. website and at the office for general public viewing.
- I acknowledge that if I misrepresent personal and financial facts to Doctor Kara, P.C. in order to obtain medical services under false pretenses or to avoid paying valid charges payable to the clinic, those misrepresentations may be construed as probable fraud. In cases of probably fraud, I can expect Doctor Kara, P.C. to do the following:

    1. file a theft report with the necessary authorities,
    2. provide all available supporting documents and information regarding the fraudulent activity to investigating authorities,
    3. immediate referral to a collection agency for legal action on behalf of Doctor Kara, P.C.

Patient Signature: _____ Date: _____

Special Case of Credit Card Use Permitted by the Authorized Cardholder:

I, _____, the authorized cardholder am verifying that
(authorized cardholder's printed name)

_____ who is my _____ has my
(printed name of patient) (relationship to authorized cardholder)

permission to use my credit card as the credit card of record as the form of payment for the account established with Doctor Kara, P.C. until such time that Doctor Kara, P.C. receives ***written*** notification that said permission is revoked. Doctor Kara, P.C. will confirm in writing the receipt of the written revocation notice and make other account payment arrangements with the patient immediately upon receipt of the revocation notice.

I also verify that I have reviewed the terms and conditions as outlined in this document and clinic website and agree to abide by those terms. Future changes in terms and conditions will be posted on the clinic website and in the office and may be in effect without prior written notice.

Authorized Cardholder's Signature: _____ Date: _____

TREATMENT AUTHORIZATION AND CONSENT FORM

I hereby consent and authorize Kara Diersing Clapp, PhD NP-c, a certified Family Nurse Practitioner, to assess, diagnose, and treat any and all medical conditions I may have as a voluntary client of Doctor Kara, PC Nurse Practitioner Clinic located at 880 East 9400 South Suite 116 in Sandy, Utah 84094.

I also understand that I may be referred to other professional health care providers and services and hereby consent to any recommended medically necessary referral as a part of my treatment plan. In the event I fail to adhere to my treatment plan or fail to schedule and maintain timely follow up with said referral, I hereby release Doctor Kara, P.C. Nurse Practitioner Clinic from liability related to any further injury, disability or death resulting from my failure to comply with recommended medical referrals.

Timely compliance is defined as 15-30 minutes for any life threatening condition, 1-4 hours for very urgent medical conditions, and 5-12 hours for moderately urgent medical conditions. All referrals of life threatening and imminently life threatening nature will be made to an emergency room nearest the location of the clinic, which is Alta View Medical Center at 1300 East and 9400 South in Sandy Utah. At the time of my office visit, I understand I will be advised of the urgency of my condition and the type of recommended referral being made as defined above.

For referrals that are not immediately or imminently life-threatening, all follow up is expected to be completed within 14-30 days of the date the recommended referral was made. Examples of this type of referral may include, but are not limited to: follow up of normal/abnormal test or procedure results by a specialist physician, referral for additional assessment and treatment by a medical specialist physician, medically-complex illnesses and conditions that are beyond the scope of practice of the nurse practitioner in the state of Utah.

I also understand the clinic will use the contact information I provided (which has been recorded in my medical record) to send written communication, verbal phone calls, or email. It is my responsibility as a client to provide updated information in writing to the clinic in event of any changes in my personal contact information. In the event I fail to maintain updated contact information in writing, I release Doctor Kara, P.C. Nurse Practitioner Clinic from any and all liability that results in injury, disability or death as a result of written and verbal communications that fail to reach me at the appropriate address, phone number, or email address.

In the event of any disputes arising from a treatment plan or medical services rendered by the clinic, I agree to contact Kara Diersing Clapp, PhD, NP-c in writing within 14 days and agree to submit the dispute within 30 days to arbitration services for final and binding resolution.

_____ (initial here) For non-VIP members there is a $25.00 surcharge for after-hours appointments. VIP members receive a fee waiver from 6-11 pm Mon-Thurs, as it is a regular service feature of the VIP program.

_____ (initial here) I understand I am being treated by a Certified and Licensed Family Nurse Practitioner who has a PhD and the Doctor Kara, P.C. logo refers to a non-MD provider.

Client Name (Printed) _____ Date _____

Client Signature _____

doctor kara, PC

Original Date: 11/01/06

Dates Revised: 03/01/12

Kara Diersing Clapp, PhD, NP-c
Family Nurse Practitioner
880 East 9400 South #116, Sandy UT 84094
Phone: 801-495-9303 Fax: 801-495-9670

CLIENT AGREEMENT: CONTROLLED SUBSTANCE CLASS II-III

This agreement is strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F **DOB**:

Social Security Number (last 4 digits only):

TERMS AND CONDITIONS OF THIS AGREEMENT:

1. I understand that initial treatment consultation will provide only 3 days of controlled substance before requiring a follow-up visit with Dr. Kara.

2. I understand that subsequent treatment consultation will provide only a 7-day supply of controlled substance before requiring a follow-up visit with Dr. Kara.

3. I understand that only a 30-day total supply of controlled substance may be provided by Dr. Kara as treatment of acute pain. Pain that remains unresolved after 90 days will require a referral to a pain specialist for further evaluation and treatment.

4. I agree to receive controlled substances from Dr. Kara only and will not seek additional controlled substances from other providers, clinics, hospitals, Emergency Room departments.

5. I understand that Dr. Kara may elect to request a DOPL report from the state of Utah without my knowledge or consent to confirm that I have not violated the terms of this agreement.

6. I agree to maintain my follow-up appointments with Dr. Kara as scheduled. In the event I cancel an appointment, I will not expect Dr. Kara to renew my controlled substance prescriptions until she has completed a face to face assessment of my condition and response to treatment.

7. To facilitate provider communications with other treatment plan team members, **I agree to have my controlled substance prescriptions filled only by the following pharmacy**:

Pharmacy Name Address and Phone Number: _____

8. I agree to maintain current and correct contact information with Dr. Kara during the time I am receiving controlled substances from her.

9. I agree to maintain personal custody of and control over my controlled substances to prevent accidental loss or theft. I understand that I cannot ask Dr. Kara to replace them in the event of accidental loss or theft, regardless of the circumstances of the loss or theft.

10. I understand that my privilege to receive controlled substances from Dr. Kara, as a part of my medical treatment plan, will remain intact as long as I maintain the conditions of this agreement. In the event that I do not follow the conditions of this agreement, Dr. Kara has the right to terminate her willingness to provide me with controlled substances as a part of my treatment plan. Violations of this agreement do not terminate my non-pharmaceutical portion of the treatment plan. I understand that Dr. Kara will use my contact information to provide me written notice within 3 business days of the termination of controlled substance portion of my treatment plan. It is my responsibility to notify Dr. Kara of any changes in my contact information.

11. (**Interim Chronic Pain Clients Only**) I am scheduled with _____ on_____
I acknowledge that I may receive controlled substances from Dr. Kara only until the date of the appointment as listed above or until Dr. Kara has confirmed that the Pain Specialist is able to assume responsibility for the treatment plan established by the specialist. Appointment cancellations and reschedules initiated by me will void the contract I have with Dr. Kara. In the event of appointment reschedules initiated by the pain clinic, Dr. Kara will confirm the re-schedule request with the pain clinic in order to validly and potentially extend the length of this interim contract.

SIGNATURES:

Client Signature:

Date:

Provider Signature:

Date:

NEW PATIENT MEDICAL HISTORY FORM

First Name: _____ Last Name: _____ DOB: _____

Allergies to Drugs: N Y (Please list): _____

Allergic to Foods: N Y (Please list): _____

Medications and Herbal Supplements You Currently Take: (Please enter dose also)

_____
_____
_____
_____
_____

Medical History: Please put an X in any box that apply.

	Me	Dad	Mom	Sibling	Grand parents		Me	Dad	Mom	Siblings	Grand parents
Allergies (seasonal)						Heartburn					
Anemia						Back Pain					
Arthritis						High BP					
Asthma						High Cholesterol					
Atrial Fib						Low Thyroid					
Chest Pain						Insomnia					
Circulation Problem						Irritable Bowel					
Heart Failure						Kidney Failure					
Depression						Migraines					
Diabetes						Mitral Valve Prob.					
Emphysema						Osteoporosis					
Gout						Sinusitis					
Headaches						Skin Disorder					
Hearing Loss						Stroke					
Heart Attack						ImpairedVision					
Anxiety						Cancer					
Panic Attacks						Reflux					

Other Medical Problems not listed above:

_____
_____

Surgeries (include year):

_____
_____
_____

Alcohol Use: N Y Amt/wk: _____ beer /wine/liquor Smoker: N Y Amt/day: _____ for _____ years.

REVIEW OF SYSTEMS: (patient checklist)

Instructions: Circle all symptoms that have bothered you over the last 3 months.

General: fever, chills, feeling flu-like, fatigue, drastic changes in energy levels, night sweats, unintended weight loss or weight gain in the last 12 months.

Diet: changes in appetite (more hungry/less hungry), diet restrictions, vitamin/herbal supplements

Skin, Hair, Nails: rashes, itching, changes in skin color, changes in nails

Head & Neck: headaches, dizziness, head injuries, loss of consciousness

Eyes: blurring, double vision, visual changes, change in prescription glasses, eye trauma, eye disease

Ears: hearing loss, pain, discharge, ringing in the ears, sensation of the room spinning/ of spinning inside your body

Nose: congestion, nose bleeds, post-nasal drip

Throat & Mouth: hoarseness, sore throat, bleeding gums, ulcers, tooth problems, bad breath, difficulty swallowing, sensation of lump in throat.

Gastrointestinal: indigestion, heartburn, vomiting, bowel changes, changes in regularity

Lymph Nodes: tenderness or enlargement in nodes of neck or groin area

Endocrine: heat or cold intolerance, excessive urination, excessive thirst, hair changes, changes in neck size or appearance, increased shoe size

Chest & Lungs: cough, sputum, shortness of breath, shortness of breath with exertion, chest tightness or pressure, night sweats, exposure to TB or other respiratory illnesses.

Cardiovascular: chest pain, palpitations, number of pillows used to sleep, edema, pain in calf muscle with exercise, inability to exercise due to intolerance or shortness of breath, jaw or arm pain.

Hematology: anemia, easy bruising, blood in stool (bright red or black tarry), coffee ground vomit

Genitourinary: painful urination, flank (mid-back) pain, urine urgency or frequency, excessive night time urination, blood in urine, urine dribbling, unexpected and unintended loss of bladder control or bowel control.

Musculoskeletal: joint pain, heat in joint, redness or swelling, excessive muscle aches

Neurological: fainting, weakness, loss of coordination, seizures, migraine headaches, loss of consciousness

Mental Status: lack of concentration, insomnia, changes in socializing, mood changes, suicidal thoughts or attempts.

Female: Breast: pain, tenderness, discharge, lumps, previous sexually transmitted infections, abnormal Pap Smear results. Menopause. Infertility. Changes in sex drive

Male: changes in erections, testicular pain, discharge from penis, changes in sex drive, infertility. Changes in stream of urine, changes in urination patterns.

Pediatrics (under age 12 yrs): bed wetting or fecal incontinence after toileting trained, inability to sleeping alone, bullying, pica (eating unusual non-food items), unusual fussiness, exercise/play intolerance, excessive hitting/bullying of other children, hyperactivity, other: _____

doctor kara, PC

880 East 9400 South Suite 116 Sandy Utah 84094 Phone: 801-495-9303 Fax: 801-495-9670

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:		Date of Birth:
Previous Name:		Social Security #:
I request and authorize you to release healthcare information to Doctor Kara, P.C.		
Name:		
Address:		
City:	State:	Zip Code:

This request and authorization applies to:

☐ Doctor Kara, P.C. requests the following records to assist in consultation or assumption of primary care of the patient:

- Copy of the last 5 office visits
- Copy of the most recent history and physical completed by an MD/NP/PA
- Copy of current medication list
- Copy of current and past diagnoses/problem list
- List of specific conditions treated with controlled substances II-V at present or in the past

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No	I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
☐ Yes ☐ No	I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature:	Date Signed: