

# Tracy Sinha Khona, M.D.

Allergy, Asthma, Hives & Immunology, **35+ Years Patient Satisfaction**

Phone: (904)733-6487 (24 hrs.), Fax: (904)733-6542

E-mail: [tkhona@gmail.com](mailto:tkhona@gmail.com) URS: [www.khona.com/allergy/](http://www.khona.com/allergy/)

4131 University Blvd. S. # 4A  
Jacksonville, FL 32216-4322  
Mon (pm), Tue, Thu & Fri

96279 Brady Point Road  
Fernandina Beach, FL 32034  
Wednesday (am)

205 Zeagler Drive, # 501  
Palatka, FL 32177  
Monday (am)

## PATIENT INFORMATION SHEET

Date: \_\_\_\_\_

Patient Name (Last, First) \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_ Cell Phone \_\_\_\_\_

Business/Home Phone \_\_\_\_\_

Social Security No. \_\_\_\_\_ Fla. Driver License # \_\_\_\_\_

Relationship to Insured Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

If other, who is the responsible party? \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

What is your Occupation? \_\_\_\_\_ Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_

Patient's Spouse \_\_\_\_\_ Social Security Number \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Person to contact in case of Emergency \_\_\_\_\_ Phone No. \_\_\_\_\_

Who referred you to this office? Physician \_\_\_\_\_ Friend \_\_\_\_\_ Emergency Room \_\_\_\_\_

Hospital \_\_\_\_\_ Phone Book \_\_\_\_\_ Other \_\_\_\_\_

## INSURANCE INFORMATION

**PRIMARY INSURANCE COMPANY** \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Name or Number \_\_\_\_\_

**SECONDARY INSURANCE COMPANY** \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Name or Number \_\_\_\_\_

If patient is a minor, parent or guardian, please complete following:

Mother \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Social Security # \_\_\_\_\_

Mother \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Social Security # \_\_\_\_\_

**NOTICE:** Effective January 1, 2017, we will begin to charge a fee of **\$25** to patient; when they **DO NOT show up** for scheduled appointment. You may call our office at 904-887-5678 and cancel your appointment, **24 hours** prior to your appointment time.

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Date: \_\_\_\_\_

**Please read the following Health Insurance information and mark appropriate boxes and sign below:**

I have NOT met deductible for 2023

I have met deductible for 2023 and I have EOMB as proof.

My deductible for the year 2023 is \$ \_\_\_\_\_

I understand that I am responsible for deductibles and all CO-Pays.

I authorize the release of any medical or other information necessary to process the Insurance claim. I also request payment of government benefits and/or medical benefits and for medical services is due to Dr. Tracy Sinha Khona, MD.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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I, \_\_\_\_\_ understand that when Dr. Tracy Sinha Khona is out of town or cannot be reached by telephone, that I, in case of an allergy / asthma emergency, shall go to the nearest EMERGENCY ROOM or call the primary Physician.

DO NOT sign, if you do not understand.

**Primary Care Physician:** \_\_\_\_\_

Phone No. \_\_\_\_\_

Fax. No. \_\_\_\_\_

**Pharmacy Name:** \_\_\_\_\_

Phone No. \_\_\_\_\_

Fax No. \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- You may Refuse to Sign this Acknowledgement

I, \_\_\_\_\_ have received and reviewed

the copy of this office's Notice of Privacy Practices.

Please Print Name: \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

### For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited us from obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_

\_\_\_\_\_

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## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

### SECTION A: PATIENT GIVING CONSENT

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Patient # \_\_\_\_\_

Social Security No.: \_\_\_\_\_

### SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENT CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practice: You have the right to read our Notice of Privacy Practice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact person: **T. Sinha Khona, M.D.**

Telephone No.: **904-733-6487**

E-mail: [tkhona@gmail.com](mailto:tkhona@gmail.com)

Address: **4131 Univ. Blvd. S. # 4A, Jacksonville FL 32216-4322**

Right to Revoke: You will have the right to revoke this Consent at any time on giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decide not to treat you or to continue treating you, if you revoke this Consent.

Signature: \_\_\_\_\_

I have had full opportunity to read and consider the contents of this Consent form and your Notice of privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use of and disclosure of my protected health information to carry out treatment, payment activity and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete following:

Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

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Dear Patient:

Date: \_\_\_\_\_

With the recent changes in the insurance industry, and Medicare, we must bring to your attention the following:

In the event that, as a patient, the total amount billed for services is not covered by Medicare, and/or the patient's primary or secondary insurance coverage, any shortfall in payment shall be the sole responsibility of the patient. Dr. Tracy Sinha Khona, shall bill patient for all applicable charges for services rendered, that are not paid by patient's insurance provider, including co-pays not received at the time of treatment, or procedures/treatments not covered by patient's insurer. This shall be considered "credit granted" by Dr. Tracy Sinha Khona's practice, and any amounts due and invoiced must be paid within 30 days of the date that the invoice is generated by the office of Dr. Tracy Sinha Khona, and sent to the patient via U. S. Mail.

As such, the patient and/or parties responsible for payment agree to the following:

I / We understand and agree that any invoice due and payable for services rendered by Dr. Tracy Sinha Khona, shall be paid promptly in accordance with terms and agreements as outlines above, shall be considered past due if not paid within 30 days of the invoice date, and in the event of default to pay a fifty dollars (\$50.00) collection charges and/or attorney fees associated with collection of such delinquent account, a fee of fifty-five dollars (\$55.00) shall be imposed for any checks that are returned for insufficient funds or non-payment.

Agreed by undersigned patient and party responsible for payment.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Signature of Party Responsible for Payment and Relationship to Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

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## NOTICE OF PRIVACY ACT PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND  
DISCLOSED AND HOW YOU CAN ACCESS TO THIS INFORMATION  
PLEASE REVIEW IT CAREFULLY

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice when it is in effect. The Notice takes effect 04 / 14 / 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed as the end of this Notice.

### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your healthcare information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person in the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Person Involved In Care;** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, you personal representative or another person responsible for you care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person in pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Service:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.