CHONG LIU, M.D., P.A.

PATIENT CONSENT FORM

I understand that as part of my healthcare, *Dr. Liu of Family Medicine* originates and maintains health records describing my health history, symptoms, examination and test results and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for serviced provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The Dr. Liu's *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be sued and disclosed. I have been provided a copy of and access to the Notice of Privacy Practices and understand that I have the right to review the notice prior to signing this consent. I understand that the Dr. Liu reserves the right to change the Notice of Privacy Practices. Prior to implementation of the revised Notice of Privacy Practices, the revised Notice will be provided to me at my next office visit or have it to be mailed to me. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that the Dr. Liu is not required to agree to the restriction requested. I may revoke this consent at any time in writing except to the extent that the Dr. Liu has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

For all medical records that will a fee of $ 25 or more!

□ I request the following restrictions on the use and/or disclosure of my personal health information.

_____

_____

_____

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed Dr. Liu's *Notice of Privacy Practices* dated _____ of _____

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Print Name of Patient or Legal Representative Date

CHONG LIU, M.D.
7712 SAN JACINTO PLACE STE 100
PLANO, TX. 75024

PATIENT REGISTRATION

Welcome to Dr. Chong Liu Family Medical Office. We are committed to provide you the best, most comprehensive health care possible. We encourage you to ask questions. To better assist you, please provide us the following information. All information is confidential and only it is released with your consent. **Please fill in all blanks below the line (please print):**

Patient Name(Last, Middle, First)	Today's Date	Date of Birth	Age	Sex

Parent if Patient is a Minor **Preferred Language:** **Race:**
English, Chinese, Spanish, Other_____ White, Hispanic, Black or African American, Asian

Social Security Number	Driver's License No.	Home Phone

Home Address City State Zip	Work Phone

Occupation	Email	Cell:

Spouse Name Employer's Name and Address

NOTIFY IN CASE OF EMERGENCY

Name Relationship	Home Phone

Address City State Zip	Work Phone

FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES

Policy Holder's Name Relationship	Home Phone

Policy Holder's DOB: SS#	Work Phone

Insurance Company	Effective Date	Member ID#	Group/Plan #

Employer of Policy Holder	Insurance Phone Number

Secondary Insurance	Claim Address & Phone #	Member ID #	Group/Plan#

Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN #	Relation to Patient

Insurance Notice and Return Check Policy

It is the patient's responsibility to know their benefits and the requirement of their insurance plan

Chong Liu Family Medicine, PA will file your claim to those insurance companies with which we have current contracts. In order to do so, we will need all current information regarding your health insurance each office visit. Patients will be responsible for any deductibles, co-payment or non-covered services at the time of the visit. Deductibles not estimated to be covered by your insurance are due at the time of service. All estimates given are estimates only based on the information provided to us by your insurance company. Any questions regarding payment or nonpayment by insurance should be directed to your insurance company. Chong Liu Family Medicine, PA main goal is to provide the best quality of care for their patients. The doctors or staff Chong Liu Family Medicine, PA will not perform any services that they do not feel are reasonable or necessary for your well-being. Many insurance plans require authorization for certain tests, referrals, ER visits, and/or treatment. If your plan requires authorization you must obtain them prior to treatment. Without the proper authorization, your insurance may refuse to pay, and you will be responsible for all charges. It's patient's responsibility to notify Chong Liu Family Medicine, PA of any change in insurance coverage. There is a $25 charge for all returned checks.

I have read and fully understand the above information

Signature: _____ **Date:** _____

Authorization and Consent

I hereby authorize the physicians and staff of Chong Liu Family Medicine, PA to release any information acquired in the course of my treatment to my insurance company or third party payers as required for claim filed quality assurance, health plan administration, or complaint/grievances. I understand that the specific information to be released may include, but not limited to history, diagnosis and/or all related illness including HIV virus, Acquired Immune Deficiency Syndrome (AIDS), and mental health.

I authorize direct payment to be made to the physicians of Chong Liu Family Medicine, PA for any and all medical or surgical services rendered. I understand that if any services or charges are not covered, or Chong Liu Family Medicine, PA is unable to verify eligibility that I am responsible for all charges inquired for services rendered.

Signature: _____ **Date:** _____

CHONG LIU, M.D. PA
FAMILY MEDICINE
7712 SAN JACINTO PLACE
PLANO TX 75024
PHONE: 972-669-1212 FAX: 972-669-1313

CONSENT FOR TREATMENT

The undersigned, as the patient or on behalf of the patient, hereby consents to and authorizes all diagnostic and therapeutic treatment considered necessary and advisable by the medical staff of the practice to include: physical exam, medical and surgical treatments and procedures, emergency treatment or services, laboratory procedures, injections vaccinations and x-ray exams.

_____
Signature of patient Date

CONSENT FOR THE TREATMENT OF MINORS

These rights are subject to a court order affecting the rights and duties of the parents (Texas Family Code §151.003.) In order for the treatment of minors to be administered, the consent must be writing and must include:

Name of Child: _____

Name of One or Both Parents: _____

Name of Any Managing Conservator or Guardian: _____

Name of Person Giving Consent and Relationship with the Child: _____

Statement of the Nature of the Medical Treatment being given: _____

Date of Treatment is to Begin: _____

Signature of Parent or Legal Guardian: _____

Witness: _____ Date: _____

PAST HISTORY OF SYMPTOMS

Yes	No		Yes	No	
Head and Neck			**Genitourinary**		
□	□	Decreased hearing	□	□	Painful Urination
□	□	Ring in ears	□	□	Blood in urine
□	□	Frequent ear infections	□	□	Frequent Urination
□	□	Dizzy Spells	□	□	Night Time urinary Frequency
□	□	Failing vision	□	□	Loss of control of urine
□	□	Double vision	□	□	Decrease in force of urine
Stream			**Endocrine**		
□	□	Blurred vision			
□	□	Eye pain	□	□	Chronic fatigue
□	□	Repeated eye infections	□	□	Weight loss-recent
□	□	Dental disease	□	□	Bruise easily
□	□	Sinus trouble	□	□	Cold extremities
□	□	Frequent sore throats	□	□	Tremors (shaking of hands)
□	□	Neck swelling	□	□	Convulsions
□	□	Hay fever	□	□	Muscle weakness
Respiratory			**Neurological**		
□	□	Hoarseness	□	□	Numbness
□	□	Persistent cough	□	□	Tingling sensations
□	□	Blood in spit	□	□	Headaches
□	□	Shortness of breath	□	□	Nervousness
Cardiovascular			□	□	Memory Loss
□	□	Chest pain traveling down left arm	□	□	Moodiness
□	□	Palpitations	□	□	Difficulty falling asleep
□	□	Irregular heart beat	□	□	Difficult staying awake
□	□	Swollen ankles	□	□	Increased irritability
□	□	Fainting spells			
□	□	Pain in legs when walking			
Digestive			**Musculoskeletal**		
□	□	Difficulty swallowing	□	□	Neck Pain
□	□	Indigestion or heartburn	□	□	Joint swelling
□	□	Nausea/vomiting	□	□	Low back pain
□	□	Change in bowel habit	□	□	Foot pain
□	□	Diarrhea	□	□	Stiff joints
□	□	Constipation	**Skin**		
□	□	Blood in bowel movement	□	□	Rash
□	□	Black bowel movement	□	□	Hives
□	□	Jaundice	□	□	Moles

Others: _____

CURRENT MEDICATION TAKING 1. _____

2. _____

3. _____

4. _____

5. _____

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PAST HISTORY OF DISEASES

Have you had in the past?

Yes	No		Yes	No	
□	□	Measles	□	□	Rheumatoid Arthritis
□	□	Mumps	□	□	Osteoarthritis
□	□	German Measles	□	□	Stroke
□	□	Polio	□	□	Hernia (groin)
□	□	Chicken Pox	□	□	Peptic Ulcer Disease
□	□	Diphtheria	□	□	Gallbladder Disease
□	□	Scarlet Fever	□	□	Diverticulitis
□	□	Rheumatic Fever	□	□	Urinary Track Infection
□	□	Infectious Mono	□	□	Kidney Stone
□	□	Anemia	□	□	Prostate Disease
□	□	Hypothyroid Disease	□	□	Depression
□	□	Hyperthyroid Disease	□	□	Mental Disorders
□	□	Pneumonia	□	□	Sexually Transmitted Diseases
□	□	Bronchitis	□	□	Hepatitis
□	□	Emphysema	□	□	Hemorrhoids
□	□	Heart Attack	□	□	HIV
□	□	Disease of arteries	□	□	Eczema
□	□	Phlebitis	□	□	Psoriasis
□	□	Varicose Veins	□	□	Cancer
□	□	Diabetes	□	□	Serious Injuries (include fractures)
□	□	Hypertension	□	□	Other

Past Surgical History: _____

1. _____

2. _____

3. _____

Allergic to Medicine: _____

1. _____

2. _____

3. _____

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