PATIENT INFORMATION

Patient Name:
Last: First: Middle int:

Address: Apt# Primary phone:

City: State: Zip: Cell:

Date of birth: Social Security#: Email:

 Male Female Single Married Divorced Widowed Ethnicity: Hispanic Non-Hispanic

Race (circle): White Black Hispanic Asian Native American Pacific Islander Other Preferred Language:

Patient's Employer: Occupation:

Employer Address: Wk Phone:

City: State: Zip:

Emergency Contact: Relationship: Phone:

Referred by:

IF DIFFERENT FROM ABOVE – POLICY HOLDER/INSURED INFORMATION – Primary Insurance

Insured's Name: Phone:

Date of Birth: Social Security#:

Employer: Wk Phone:

Primary Insurance: **Phone:**

Policy# **Group#**

SECONDARY INSURANCE (if applicable)

Insured Name:

Date of Birth: Social Security# Phone:

Employer: Wk Phone:

Secondary Insurance: **Phone:**

Policy# **Group#:**

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

The above information is complete and correct. I authorize release of information necessary to file a claim with my insurance company and I assign benefits to Kochy M Y Tang DO PC dba M Family Care. We will gladly file your insurance claim, however payment for copays and deductibles are required at the time services are rendered. We cannot guarantee payment to Kochy M Y Tang DO PC dba M Family Care. We have an agreement with you, not your insurance company for payment. In the event your insurance company denies a claim, you will become responsible for all amounts not covered payable to Kochy M Y Tang DO PC dba M Family Care. Parents/Guardians are responsible for services rendered to a minor. If your account is turned over for outside collections, you will be responsible for all costs of the outside collection agency.

I authorize release of all medical records to referring and primary care physicians and the insurance company, as applicable. I authorize fax transmission of medical records of necessary.

SIGNATURE: Date:

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS IN ACCORDANCE TO HIPAA

I _____, understand that as a part of my health care, Kochy M Y Tang DO PC dba M Family Care originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer (s) can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent/disclosure
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that Kochy M Y Tang DO PC dba M Family Care is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity (Insurance company, referring physician, consulting physician, hospital, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax or email.

In addition, I also give consent to Kochy M Y Tang DO PC dba M Family Care to disclose my protected healthcare information to the following person and/or people:

Name	Relationship
Name	Relationship
Name	Relationship

I fully understand and accept the terms of this consent.

X	
Patient or Legal Guardian's Signature	Date

Signature of M Family Care Employee	Date

Name (print):_____

New Office Policies

- Prescription refills will be addressed between 24-48 hours of notification.
- If an urgent prescription refill is requested, based on need, it will be addressed in 24 hours.
- Multiple NO SHOW's for appointments may result in a discharge from our practice. Not showing up for scheduled appointments is disrespectful to both our providers and patients. If an appointment cannot be kept, please call us to cancel.
- Overdue balances need to be paid before your next appointment. If a payment plan is needed, we are willing to make accomodations to help. Please talk to Shari for assistance.
- For your convenience, we can keep a credit card number on file for outstanding balances. If so, please provide the following information

  Card type: Visa Mastercard American Express Discover

  Card Number: _____ Exp: _____

  Security Code (back of card): _____ Billing Zipcode: _____

  Signature: _____

  Print:_____
- Appointment wait times may vary due to unexpected circumstances. Each patient is given the same care and consideration while in the exam room. Sometimes, more care is required and may take longer to address. If you have been waiting more than 15 minutes for your appointment, please come to the front desk to check the status of your wait time.
- Confirmations of scheduled appointments are usually done the day before. This is done by our office as a courtesy, please be responsible for your appointments.
- Dr. Tang is a preceptor for Medical Students. If you are not comfortable with speaking to our student about your medical concerns, please inform our Medical Assistant while you're in the exam room.

I have read and understand the listed policies.

Signature: _____ Date: _____

Medical History

List any Medical Problems you may have:

List all medications you are currently taking:

Medication	*Dose*	*Frequency*

List any allergies to medication:

Medication	*Allergic Reaction*

Surgeries:

Type of surgery performed	*Year surgery was performed*

Social History:

Occupation:

Do you smoke?	If yes, how much and how often?
Do you consume alcohol?	If yes, how much and how often?

Highest level of education:

How many people share your residence?

Family Medical History: List any Medical Problems that you are aware of (Diabetes, Hypertension, Cancer, etc.)
(***NO NAMES, please***)

Father:

Mother:

Sibling(s):

Children:

Other:

I certify that the above information is correct to the best of my knowledge.

X

Patient's Signature Date