DANG MEDICAL CLINIC
REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ Welfare *(Please provide coupon)* ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize DANG MEDICAL CLINIC or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

DANG MEDICAL CLINIC,PA

Financial Policy/Agreement and Assignment Information Authorization/Release of Medical Information

PATIENT NAME:_____File #: _____ NOTICE TO

OUR NEW PATIENTS: It is the policy of this office for patients to make payments (cash payments, co-payments, etc.) for services rendered at the time of each visit. Other payment arrangements (ie. payment plans) must be specifically discussed and approved by this office prior to treatment initiation. X-rays taken in this office remain the property of this office. Initials _____ ASSIGNMENT TO PAY

WORKER'S COMPENSATION PATIENTS: As a Worker's Compensation patient, you may be covered by insurance if your injury is reported at work and verified with your employer. Be sure to inform the office personnel that your injury resulted during employment. Patient is ultimately responsible for balance.

BENEFITS TO PHYSICIAN: I hereby certify that I (or my dependent, parent, or guardian) assign payment and/or medical benefits, if any, otherwise payable to me for services rendered from this office, directly to this office. I understand I am personally and financially responsible for payment in full for all charges and expenses related to my treatment not covered by this assignment and as allowed by the insurance company as per the providers contract agreement. Initials _____ AUTHORIZATION TO RELEASE

INFORMATION ACCORDING TO HIPAA: I hereby authorize DANG MEDICAL CLINIC,PA to release any information acquired in the course of my examination and/or treatment in accordance to HIPAA (Health Insurance Portability and Accountability Act) guidelines. The release of information will include but not be limited to the processing of medical claims or information requested by insurance companies and/or other legal representatives after which proper authorization is received at this office. I understand and agree to the release of my health information as stated in the office policy which is in accordance to HIPAA guidelines. Initials _____

SIGNED_____**DATE**_____ (Patient or parent if a minor)

WITNESS_____**DATE**_____

ADULT PATIENT INFORMATION

We strive to keep all information in confidence and we will not release information without signed consent. If referred, your information may be sent to consultants.

NAME: _____ **DATE:** _____

BIRTH DATE: _____ **AGE:** _____ **GENDER:** M / F

MARITAL STATUS: ( ) Single ( ) Married ( ) Widowed ( ) Separated ( ) Divorced

OCCUPATION(S): _____

REASON FOR VISIT TODAY:

PREFERRED PHARMACY: _____ PHONE #: _____

PREVIOUS PHYSICIAN: _____ PHONE #: _____

MEDICAL CONDITION(S)/HOSPITALIZATION(S): (Example: Diabetes, High Blood Pressure, Asthma...)

ALLERGIES: (Medications, food, insects...) _____

CHILDHOOD ILLNESSES: ( ) Chicken Pox ( ) Measles/Rubeola ( ) Mumps ( ) Rubella ( ) Scarlet Fever

SURGERIES: (Example: Tonsillectomy, Gallbladder, Hernia Repair...)

TYPE OF SURGERY	**YEAR**

MEDICATIONS: (List all including ones not prescribed such as alternative agents or herbal agents)

DRUG	**STRENGTH**	**HOW OFTEN YOU TAKE PER DAY**	**LENGTH OF TIME TAKEN**
ex. Advil	200 mg	3 times per day	6 months

Please know what drugs and doses you take. If you need refills, please let the nurse know when you are placed in the exam room.

Advance Directives: **Please discuss with your spouse or family and your physicians.**

Living Will ( ) Yes ( ) No Organ Donor ( ) Yes ( ) No Durable Power of Attorney for Health Care ( ) Yes ( ) No

Consent for Treatment

By signing this consent, I am authorizing my physician, and/or other individuals he or she deems appropriate, to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Dang Medical Clinic unless revoked by me orally or in writing.

Please be informed, Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV)—the virus associated with AIDS—in any one of the following situations:

1. To screen blood, blood products, organs or tissues to determine suitability for donation.
2. If another individual is accidentally exposed to a patient's blood or body fluids, such as through a needle stick. (Any such test shall be conducted pursuant to Texas Department of State Health Services' infectious disease protocol.)
3. If a medical or surgical procedure is to be performed which could expose healthcare workers to the patient's blood or body fluids.

This disclosure is to inform you that you may be tested, at the expense of Dang Medical Clinic, if any of these situations occur during your treatment period.

Patient's Printed Name _____ **Date of Birth** _____

Patient/Legal Representative Signature _____ **Date** _____

Relationship to Patient _____

Witness _____ **Date** _____

FINANCIAL POLICY

Thank you for choosing Dang Medical Clinic as your healthcare provider. We are committed to providing excellent healthcare services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy. **All patients must read and sign this form prior to receiving services.**

- **It is your responsibility to provide us with your most current insurance information.**
- If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
- We must emphasize that, as medical providers, our relationship is with you—the patient—and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and to understand the level of services covered by your insurance company.
- If you have **Medicaid** coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and failure to notify us of Medicaid coverage will result in full financial responsibility for services rendered.
- We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance company.**
- Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.
- We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination usual and customary rates.
- Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. **However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim– regardless of our estimation.**
- **It is your responsibility to provide us with your most current billing information.**
- You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.
- We will send a statement to your billing address notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipt of the initial statement. You can call us at (817) 760-4201.
- **Payment in full is due upon receipt of the statement**. Patient balances not paid in full within 30 days of the statement issue date are deemed past due. **Past due accounts may be subject to a $5.00 monthly late fee and may be referred to a professional collection agency and/or**

attorney for further collection activity. You will be responsible to pay all collection costs incurred, including attorney's fees and court costs, if applicable.

- If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs, if applicable.
- If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from any of the physicians at Dang Medical Clinic. Failure to accept this certified letter (and/or to pick it up at the post office) serves as notice of termination of services.
- In the event you submit payment by check and the bank returns the check, unpaid, for any reason, we will add $25.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.
- We may charge you a "No Show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.
- **Failure to keep your account balance current may require us to cancel or reschedule your appointment.** Full payment is due at the time of service. We accept cash, checks and credit cards.

I have read and understand this Financial Policy.

Signature of Responsible Party	Date

Patient Name (Print): _____ Patient Date of Birth: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have been provided with a Notice of Privacy Practices that provides me with a more complete description of the uses and disclosures of certain health information. I understand Dang Medical Clinic reserves the right to change their Notice of Privacy Practices and, prior to implementation, will provide an updated copy on the clinic website and in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or by requesting a copy in person at my appointment.

Patient's Printed Name: _____Date of Birth: _____

Patient/Legal Representative Signature: _____Date: _____

Relationship to Patient: _____

Witness: _____ Date: _____

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Dang Medical Clinic to share my protected health information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Telephone Contact Authorization:

Home/Cell Phone_____

_____Leave detailed messages on my answering machine/voicemail

_____Leave information with person or persons identified above, who may answer phone

_____Leave message with only call-back number on my machine/voicemail

Work Phone_____

_____Leave detailed messages on my answering machine/voicemail

_____Leave messages with only call-back number on my answering machine

Signed_____ **Date**_____