Yu Wang M.D. Family Medicine

Patient Registration Form

Today's date: _____

Patient Information

Name (last, first, MI): _____ Employer: _____
Address: _____ Occupation: _____
City: _____ State: _____ Zip: _____ Work phone: _____
Home phone: _____ Alt. phone: _____
Social Security #: _____ Email: _____
Marital status: Single___ Married___ Other___
Date of Birth: _____ Sex: M___ F___

Do you give our office permission to leave a message or discuss your medical information with a family member? YES___ NO___

If yes, please provide their names and phone numbers.

Name: _____ Name: _____
Phone # (day): _____ Phone # (day): _____

Do you give our office permission to leave a message on home recorder? YES___ NO___

Consent for evaluation and treatment

I hereby consent to and authorize Yu Wang M.D. Family Medicine LLC to perform a physical examination and/ or medical treatment deemed necessary. Treatment may include, without limitation, any required examination, medical, diagnostic or laboratory tests and medical procedures ordered by the physician to be performed by the designated staff. I understand I may refuse treatment at any time. I understand that certain special medical exams such as physical exams (e.g. fitness for duty, school or sports physical) and other services are not intended to diagnose medical conditions, determine treatment needs, or replace the medical care of my personal physician.

Financial policies agreement

- If applicable, where I have insurance coverage to pay for services rendered, I hereby authorize and assign to Yu Wang M.D. Family Medicine LLC any and all payments under the terms of my applicable insurance policies, and hereby obligate each payer to make payment directly to Yu Wang M.D. Family Medicine LLC for services rendered.
- If applicable, where I am treated on a private pay basis, I understand I am responsible for payment of services in full. I have a right to ask for the charge amount before electing treatment.
- If applicable, where I am treated for a worker's compensation injury or illness Yu Wang M.D. Family Medicine LLC will seek payment from the responsible payer, which is typically the employer or the employer's worker' compensation insurance carrier, in accordance with State or Federal worker's compensation laws.
- Where applicable, I understand I am responsible to pay for deductibles, copayments and other charges in accordance with my benefit plan and determinations made by health insurance carriers, or charges determined by State or Federal worker' compensation programs.

Acknowledgement of receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices. The Notice of Privacy Practices described the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care

operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Notice of Privacy Practices can be reviewed at website www.ywfamilymedicine.com. It is also posted in the facility.

In additon to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health information to the persons indicated below.

ANY MEMBER OR MY IMMEDIATE FAMILY	YES___	NO___
SPOUSE ONLY	YES___	NO___
OTHER (please specify)	YES___	NO___

By signing this form, I acknowledge that I fully understand its contents. I authorize release of medical information to my insurance company.

Signature: _____ **Date:** _____