PATIENT INFORMATION

~~~~~~~~~PLEASE FILL OUT ALL LINES~~~~~~~~~

LAST NAME: _____ FIRST NAME: _____

MALE ____ FEMALE _____ BIRTHDATE: _____

HOME PHONE #: _____ *Can we leave a message?* YES NO

CELL PHONE #: _____ *Can we leave a message?* YES NO

ADDRESS: _____ CITY:_____ ZIP: _____

EMAIL:_____

SOCIAL SECURITY #: _____

ETHNICITY: _____ RACE:_____

PRIMARY LANGUAGE SPOKEN: _____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP: _____

EMERGENCY CONTACT PHONE#: _____

I HERBY GIVE CONSENT TO RELEASE MY MEDICAL INFORMATION TO THE FOLLOWING (I.E; LABS, MEDICATION LIST, MED HISTORY, ETC)

FULL NAME: _____ RELATIONSHIP: _____

FULL NAME: _____ RELATIONSHIP: _____

FULL NAME: _____ RELATIONSHIP: _____

I hereby authorize **Wentian (Wilson) Huang, MD** to release any and all medical (including dental) information to the above –named insurance carrier (or to a designated attorney) for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization. I have read this authorization and understand it. I hereby assign to **Wentian (Wilson) Huang, MD** all money to which I am entitled for medical and/or surgical expense relative to the services rendered by him/her, but not to exceed my indebtedness to said physician and/or surgeon. It is understood that any money received from the above named insurance company, over and above my indebtedness will be refunded to me when my account is paid in full. I understand I am financially responsible to said doctor(s) for charges not covered by this assignment. I further agree in the event of non-payment, to bear the cost of collection, and/or court cost and reasonable legal fees should this be required. By signing below you will also opt to receive reminders through email, text or phone call.

_____ _____

PATIENT'S SIGNATURE DATE

_____ _____

PARENT OR LEGAL GUARDIAN SIGNATURE RELATIONSHIP TO PATIENT

*Would you like to receive advertisement when any new vaccines or products are? available Yes/No
~~~~~~~~~

HEALTH QUESTIONNAIRE

REASON FOR VISIT

Formedic

FAMILY HISTORY *IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE*

1) Epilepsy	6) Thyroid	11) Osteoporosis	16) High cholesterol
2) Migraine	7) Hayfever	12) Arthritis	17) Alcoholism
3) Mental illness	8) Asthma	13) Heart disease	18) Hepatitis
4) Glaucoma	9) Anemia	14) Stroke	19) Cancer
5) Diabetes	10) Bleeds easily	15) High blood pressure	20)

HOSPITAL ADMISSIONS *not including pregnancies*

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING - INCLUDE THOSE YOU BUY WITHOUT A PRESCRIPTION

ALLERGIES

SUPPLEMENTS

VACCINE	YEAR OF LAST	VACCINE	YEAR OF LAST
Tetanus / Td		MMR Measles Mumps Rubella	
Influenza (flu)			
Pneumonia		Meningitis	
Hepatitis A		Chicken pox	
Hepatitis B		HPV	
Whooping C		Shingles	

MEDICAL HISTORY *MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES*

Decreased hearing
Ringing in ear
Ear infections - *frequent*
Dizzy spells Fainting spells
Failing vision Eye pain
Date of last eye exam
Double or blurred vision
Nose bleeds Sinus trouble
Sore throats - *frequent*
Hoarseness - *prolonged*
Hayfever / Allergies
Pneumonia / Pleurisy
Bronchitis / Chronic cough
Asthma / Wheezing
Date of last TB test
Shortness of breath
on exertion lying flat
in the past week
affects work / lifestyle
Chest pain High blood pressure
Date of last cholesterol test
Heart murmur Swollen ankles
Irregular pulse Palpitations
Leg pain - *when walking*
Varicose veins / Phlebitis
Cold numb feet
Loss of appetite - *recent*

Difficulty swallowing
Heartburn Peptic ulcer
Aspirin - Arthritis - Pain pills
Nausea/Vomiting Gallbladder prob
Jaundice / Hepatitis
Irritable bowel syndrome
Abdominal pain
Bloating / discomfort
Diarrhea Constipation
Diverticulosis Crohn's Colitis
Inflammatory bowel disease
Bloody or tarry stools
Test for blood in stools
Hemorrhoids Hernia
Urination - Overactive Bladder
Overnight more than twice
More than 8 times / 24 hrs
Urgency to urinate with leakage
Decrease in force/flow Painful
Stress incontinence - urine leakage
with exercise / movement
Blood in urine Kidney stones
Urine infections - *frequent*
Bed wetting
Weight loss / gain Appetite
Anemia Bruise easily
Blood transfusions

Cancer Easily fatigued
Decreased energy / endurance
Diabetes Thyroid disease
Seizures Stroke
Tremor / hands shaking
Headaches Numbness
Arthritis / Rheumatism
Bone fracture / joint injury
Osteoporosis Back pain
Foot pain Gout
Rashes Hives
Psoriasis Eczema
Excessive sweating
Concentration problems
Depression Nervousness
Agitation Memory loss
Moodiness Suicidal thoughts
Feelings of worthlessness
Phobias Mental illness
Sleep problems - how long
How frequent
Waking refreshed
Rheumatic fever Scarlet fever
Chickenpox Polio Mumps
Measles German measles
Tuberculosis Herpes

Aids / Hiv Std
Sexually transmitted diseases -
# of encounters
Sexual problems / enjoyment
Decreased work performance
Alcohol oz per week
Coffee / Tea cups per day
Smoking - cig/day # years
year quit
Exercise
Street drugs
Travel abroad

MALES - Prostate problems

FEMALES - *Please complete*
Menstrual flow:
Reg Irreg. Pain / Cramps
Days of flow Length of cycle
Date – 1st day of last period
Number of:
Pregnancies Abortions
Miscarriages Live births
Birth control method
B C pill (name)
Flushing / Menopause
Pain / Bleeding during or after sex
Migraine with nausea
Date of last Pap test
normal abnormal
Date of last mammogram
normal abnorma

NOTES

LITHO IN CANADA

Cancellation Policy/No Show Policy for Doctor Appointments

Our goal is to provide quality medical care in a timely manner. In order to do so we have had to implement an appointment/cancellation policy. The policy enables us to do better utilize available appointments for our patients in need of medical care.

1. **Cancellation/No Show Policy for Doctor Appointment**-We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. A "no show" is someone who misses an appointment without canceling it within a 24-hour working day in advance. No-shows inconvenience those individuals who need access to medical care in a timely manner. How To Cancel Your Appointment If it is necessary to cancel your scheduled appointment, we require that you call one working day in advance. Appointments are high in demand, and your early cancellation will give another person the possibility to have access to timely medical care. To cancel an appointment, please call our (972)-530-5550.

2. **Scheduled Appointments**-We understand that delays can happen, however, we must try to keep the other patients and doctors on time. If you are running late, please notify the office. If a patient is 15 minutes past their scheduled time, we may have to reschedule your appointment. The following are charges for services in the office:

No Show Fee- $25
Returned Check Fee- $25

PRINT PATIENT NAME: _____

SIGNATURE/PARENT/GUARDIAN: _____

DATE: _____

WENTIAN (WILSON) HUANG, MD, PhD., P.C.

Diplomate, American Board of Internal Medicine

3475 Collins Blvd
Garland, TX 75044

Phone 972-530-5550
Fax 972-530-3632

Nurse Practitioner/Physician Assistant Consent to Treatment

Dr Huang's staff has staff Nurse Practitioners and Physician Assistant in the delivery of primary medical care.

A Nurse Practitioner is not a doctor. A Nurse Practitioner (NP) is registered nurse who has completed specific advanced nursing education (generally a master's degree or doctoral degree) and training and can diagnose, treat, and monitor common acute and chronic diseases, as well as provide health maintenance care. In addition, the NP may treat minor lacerations and other major injuries.

A Physicians Assistant is not a doctor. A Physicians Assistant (PA) is a healthcare professional trained and licenser to a practice medicine with limited supervision of a physician. A physician. A Physician's Assistant is concerned with preventing, maintaining, and treating human illness and injury providing a broad range of health care services that are traditionally performed by a physician. Physician assistants conduct physical exams, diagnoses and treat illnesses, order and interpret tests, counsel on preventative health care, and write prescriptions. In addition, the PA may treat minor lacerations and other minor injuries, as well as perform surgical procedures.

I have read the above, and hereby consent to the services of Nurse Practitioner or Physician Assistant for my health care needs.

I understand that at any time I can refuse to see the Nurse Practitioner or Physicians Assistant and request to see a physician.

_____ _____

Patients Name Date of Birth

_____ _____

Patient/Guardian Signature Date

NOTICE OF PRIVACY PRACTICES

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

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact the person listed below.

Treatment, Payment, Health Care Operations Treatment:

We are permitted to use and disclose your medical information to those involved in your treatment. For example, your care may require the involvement of another specialist. When we refer you to a specialist, we will share some or all of your medical information with that physician to facilitate the delivery of care

Payment:

We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations:

We are permitted to use or disclose your medical information for the purposes of health care 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, and licensing or credentialing activities.

Disclosures That Can Be Made Without Your Authorization:

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight:

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using. We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled. We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement:

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed. If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena;
- Pertains to a victim of crime and you are incapacitated;
- Pertains to a person who has died under circumstances that may be related to criminal conduct;

- Is about a victim of crime and we are unable to obtain the person's agreement;
- Is released because of a crime that has occurred on these premises; or
- Is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation:

We may disclose your medical information as required by the Texas workers' compensation law.

Inmates:

If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President:

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors:

When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law:

We may release your medical information where the disclosure is required by law

Your Rights Under Federal Privacy Regulations:

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions:

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances. To request a restriction, submit the following in writing: (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to the address and person listed below. You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means:

We may telephone you and leave a message about upcoming appointments, billing matters, or negative laboratory reports. You must advise the person listed below specifically if you do not want telephone messages of the above nature left for any particular reason. You may request that we send communications of protected health information by alternative means or to an alternative location. Such requests must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information:

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be

made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed below.
We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

· Includes psychotherapy notes.

· Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.

· Is subject to the Clinical Laboratory Improvements Amendments of 1988.

· Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review. Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.
HIPAA permits us to charge a reasonable cost based fee.

Amendment of Medical Information:

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

· Wasn't created by this practice or the physicians here in this practice.

· Is not part of the Designated Record Set.

· Is not available for inspection because of an appropriate denial.

· If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Accounting of Certain Disclosures:

The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request *before* any costs are incurred.

Sign-in Sheets and Announcing of Patients in Waiting Area:

We provide a sign-in sheet for patients who have arrived at the office for their appointments. The signing-in provides a tool for the receptionists to confirm the presence of a scheduled individual as well as to provide a reference for future use. The sign-in sheet does not refer to any health information that could be associated with the patient.
A member of the clinical staff may enter the waiting room and call a patient by name when it is her time to see a provider. No information except the patient's name shall be used in the waiting area.

Appointment Reminders, Treatment Alternatives, and Other Health-Related Benefits:

We may contact you by telephone, mail, or both, to provide appointment reminders, information about treatment alternatives, or other health related benefits and services that may be of interest to you.

Complaints:

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:
U.S. Department of Health and Human Services

HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You:

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices
with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests:

If you have any questions or want to make a request pursuant to the rights described above, please contact:
Wentian Huang M.D., PhD., P.C.
3475 Collins Blvd
Garland TX 75044
Ph: (972)-530-5550
Fax: (972)530-3632
This notice is effective on the following date:
We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

Acknowledgment of Review of Notice of Privacy Practices:

I have had an opportunity to review this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name:_____ **DOB:**_____

I understand and agree that I will be financially responsible for any and all charges for services rendered or not paid by my insurance. This includes any medical service or visit, preventative exam/physical, lab or diagnostic testing, and any other screening service ordered by the physician or the physician's staff. INITIAL_____

I understand and agree that it is my responsibility and not the responsibility of the physician or staff to know if my insurance will pay for such medical service(s), preventative exam/physical, lab or diagnostic testing, or any other screening service ordered by the physician or the physician's staff. INITIAL_____

I understand and agree that it is my responsibility to know if my insurance has any Deductible, Co-Payment, Co-Insurance, Out-of-Network, Usual and Customary Limit or any other type of benefit limitation for the services I receive and I agree to make full payment. INITIAL_____

I understand and agree that it is my responsibility to know if the physician that I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician I am seeing is not, it may result in claims being denied or higher out of pocket expense to me and I understand this and agree to be financially responsible and make full payment. INITIAL_____

I hereby authorize payment of medical benefits directly to Wentian Huang M.D., PhD., P.C. for services rendered. Authorization is hereby granted to release information contained in my medical record to my insurance company or its employees/agents as may be necessary to process and complete my medical insurance claim(s). I further understand should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses, if any. The duration of this authorization is indefinite and continues until revoked in writing. A photocopy of this statement is to be considered as valid as the original.

INITIAL_____

Signature:_____

Date:_____

Print Responsible Party Name:_____