Patient Registration Form

Full Name:

First Name: ____________________________ Last Name:__________________________

Middle Name:___________________________

Date of Birth (MM/DD/YYYY): ___________________________

Social Security Number (SSN):_____________________________________
(Required for TRICARE members for authorizations)

Home Address:

Street: _____________________________ State: ______________
City: _______________________________ Zip Code: ___________

Email Address: ____

Phone Number (Please specify which is preferred):
Home: ________________________________ Mobile: _______________________________

Occupation/Retired: ____

Race/Ethnicity:
____

Language/Interpreter Needed (Yes/No):___________________________

Marital Status:_____________________________

Needs for accommodations:
____

Emergency Contact:

Name**:** _______________________________________

Relationship to Patient: _______________________________________

Phone Number: ______________________________

PATIENT FINANCIAL POLICY

Our practice is committed to providing you with the best possible medical care. Please review the following information regarding patient responsibility for the payment(s) of services provided.

Before your appointment, please review your insurance information regarding its policies on: copayments, coinsurance(s) and deductibles, which may be required. **ALL** copays are to be paid for **at the time services are provided, we do not "bill" copays**. This includes copayment, coinsurance(s) and deductibles, and any outstanding balances. If our practice participates with your insurance plan, we will bill your insurance company for services provided.

Please bring your insurance card with you and present your card for verification at each appointment. Please note that any questions or concerns regarding your insurance coverage should be directed to your insurance company. If your insurance company happens to deny or does not respond to a claim that our practice has submitted for services to you, you may be liable for your expenses. If our practice does not participate with your insurance company or you do not have medical insurance, you will be required to pay the full cost of the office visit and any procedures or tests performed. Payment for services can be made by cash, credit, or debit cards including; MasterCard and Visa.

CANCELLATION POLICY

If you cancel or reschedule your visit without one business days advance notice, or do not show for your appointment the fee is **$100**.

I have read and understand the terms and conditions in this financial policy and agree to abide by them.

Patient Signature: ___________________________________

Date: ___________________________________

COPAY/PAPERWORK POLICY

Co-payment and/or co-insurance is due at the time of service. At each visit, please be prepared to provide your insurance cards and any co-payment you may have. For cash patients, payment is due at the time of service. We accept all forms of payment. You are ultimately responsible for the payment of your bill, regardless of your insurance coverage. If payment has not been received from your insurance company within 60 days, we will expect payment from you. If you do not pay for your copay at the time of service, a $50 dollar fee will be billed in addition to the copay. Any additional paperwork needed to be filled out, will be $25 dollars per page (IHSS, 602 Forms, DMV paperwork, FMLA, physical forms, etc.). If you have any questions regarding a bill/claim, our billing department is always willing to help at (510)259-0000.

I understand that I am financially responsible for all charges, whether or not they are covered by my insurance. In the event of default, I agree to pay all costs of collection. I hereby authorize Dr. Teng, a health care provider to release all information necessary to secure the payment of benefits from my insurance carrier. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient Signature: ___________________________________

Date: ___________________________________

Annual Physical
(Preventive Care/Wellness Visit)

A visit focused on preventive care and general health status (typically copay exempt) which includes:

- Health History Review
- Medication Review
- Lab Review
- Preventive Screening
- Detailed Physical Exam

Problem Focused Visit
(Office/Sick Visit or Follow Up)

A visit to evaluate and manage new or existing medical conditions (copay and deductible will apply), examples include:

- Evaluate and Treat Symptoms and Concerns
- Address Chronic Medication Conditions
- Adjust Medications and Process Refills
- Laboratory/Diagnostic Image Review
- Process Referrals (If Necessary)
- Form Completion

I have read and understand the difference between annual physical exams and problem focused medical office visits described above. I also understand the copay will be collected if new or chronic conditions require additional work up and evaluation.

Patient Signature: ___________________________________ Date: ___________

HIPAA Acknowledgement & Release Form

Notice of Privacy Practices

Printed Name:_________________________________Date of Birth: ___________

We, at Teng Medical Foundation, are required by law to maintain the privacy of and provide individuals with access to the Notice of our legal duties and privacy practices with respect to protected health information. I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document and understand that I may obtain a copy for my records upon request.

Release of Information

Please let us know how your personal health information may be released

☐ I am the only one who should receive information regarding my personal health information. Best way to contact me

☐ Home phone __________________________ Permission to leave a message **Y N**

☐ Cell Phone ____________________________ Permission to leave a message **Y N**

☐ I, ___________________________, authorize the release of my medical information including diagnosis, records, examination rendered to me and claims information. This information may be released to:

____

Signed: ____ Date ______________

Witness: ____ Date _______________

RELEASE OF INFORMATION

I, _______________________________, do hereby authorize and request

____

to release any and all records, reports, charts, examination and/or test results, notes, etc., to Teng Medical Foundation.

The disclosure of this information is required to access and request medical records, file authorization for services and medications, and any legal cases.

This authorization expires on______________________________________, or 5 years from the date of signature, whichever is sooner.

Photocopies of this authorization shall be considered as valid as an original. I understand that I may receive a copy of this authorization.

Signed: _______________________________________ Date: ________________________ Witness: ______________________________________ Date: ________________________

Teng Medical Foundation

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