Pachie Chan M.D

Patient Registration Form

Welcome to Our Practice!

PATIENT INFORMATION

Name: ____
Address: ______________________________________
City: _________________State: _______ Zip: ________
Home Phone: ____________________________________
Work Phone: ____________________________________
Cell Phone: _____________________________________
Do you have a Advanced Directive [ ] Yes [ ] No
Do you have a Medical Power of Attorney [ ]Yes [ ] No

Email: ____________________ Sex: [ ]M [ ]F
Date of Birth:________________________
Social Security #: ________________________
Marital Status: [ ] Married [ ] Single
Race; [ ] Asian [ ] Black or African American
[ ] White [ ] Hispanic [ ] Other _________
Primary Language: _____________________
Code Status [ ] Full Code [ ] Out of Hospital DNR

PATIENT EMPLOYMENT

[ ] Employed [ ] Retired [ ] Not Employed
Employer:____ Phone: ____

EMERGENCY CONTACTS

Name: __________________________________ Phone Number ________________________ Relation: ____________
Name: __________________________________ Phone Number ________________________ Relation: ____________

RESPONSIBLE PARTY (Must complete if responsible party is other than the insured or patient.)

[ ] Same as Patient [ ] Same as Insured
Name: ____
Address: ____
City, State, & Zip: _________________________________

Relation to Patient:______________________________
Employer: ____________________________________
Phone: _______________________________________
Date of Birth: _________________________

MEDICAL INSURANCE

Do you have Medical Insurance? [ ] Yes [ ] No
Name of Insurance: ________________________________ Policy Holder Name: ________________________________
Guarantor's DOB: __________________________________ Guarantor's SSN: ___________________________________

Do you have a Secondary Insurance? [ ] Yes [ ] No
Name of Insurance: ________________________________ Policy Holder Name: ________________________________
Guarantor's DOB: __________________________________ Guarantor's SSN: ___________________________________

PHARMACY INFORMATION

Pharmacy: ____ Pharmacy Phone # : _____________________
Pharmacy Location: ____

Electronic Prescriptions

__________ I voluntarily authorize Pachie Chan M.D. PLLC to allow E-prescribing for my prescriptions, which
Please Initial allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluations and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor

___________________________________ ____________________________ _________________________
Patient or Guardian Signature Relationship to Patient Date

PATIENT AUTHORIZATION TO RELEASE PROTECTIVE HEALTH INFORMATION
TO DESIGNATED REPRESENTATIVE(S)

I, ____ give my authorization to release my protective health information including results of my laboratory test, x-rays and or other test results to the following designated representatives(s)

Patient Initials:

____________ You may not share any information with anyone including spouse or family members .

____________ My Spouse (Name) ____

____________ My Child (Name) ____

____________ Other (Name) ____

____________ Other (Name) ____

Circle Yes or No

Yes No Dr Chan's office may mail results to me.

Yes No Dr Chan's office may release medical records to referring physicians.

I prefer to be contacted in the following Manner:

Phone # (   ) ______________

___ Leave message with detailed information
___ Leave message with contact number only
___ DO NOT leave Message

Phone# (   )__________________

___ Leave message with detailed information
___ Leave message with contact number only
___ DO NOT leave Message

____

Patient Signature Date

____

Witness Date

PACHIE CHAN M.D. PLLC

Past Medical History

Please list all Medications you are taking both prescription and over-the counter (you may use back of page if necessary)

Name of Medication   Dosage   How is it taken   Reason for taking it

______________________________   __________   ____________________________   ____________________________
______________________________   __________   ____________________________   ____________________________
______________________________   __________   ____________________________   ____________________________
______________________________   __________   ____________________________   ____________________________
______________________________   __________   ____________________________   ____________________________

Please list all Medications you are allergic to or have had a reaction to

Name of Medication   Reaction to Medication

____   ____
____   ____
____   ____

Past Medical History

Have you ever been diagnosed with or experienced any of the following? Please check all that apply

[ ] Allergies	[ ] Liver Disease/Jaundice	[ ] Gonorrhea/Herpes/HIV/Syphilis
[ ] Arthritis	[ ] Prostate Problem	[ ] Headaches
[ ] Asthma	[ ] Shortness of Breath	[ ] Heart Attack
[ ] Bleeding Disorders	[ ] Stroke	[ ] Hepatitis
[ ] Blood in Stool	[ ] Ulcers	[ ] High Cholesterol
[ ] Breast Lump	[ ] Difficulty Hearing	[ ] Kidney Disease
[ ] Cancer	[ ] Digestive Problems	[ ] Memory Loss
[ ] Cataracts	[ ] Dizzy Spells	[ ] Seizures
[ ] Chest Pain/ Pressure/ Tightening	[ ] Eczema	[ ] Skin Disorders
[ ] COPD	[ ] Frequent Urinary Infections	[ ] Tuberculosis
[ ] Depression	[ ] Gall Bladder Disease	[ ] Other: ___________________________
[ ] Hypertension	[ ] Glaucoma	[ ] Other: ___________________________

Please list all surgeries you have had

Surgery   Date   Doctor/Location

____   ___________   ____
____   ___________   ____
____   ___________   ____

Family History

Please check if any of your family have any of the following medical problems and please indicate which relative in the space.

Family Member	Alive	Deceased	Year of Birth	Diabetes	High Blood Pressure	Cancer	Heart attack/stroke
Mother							
Father							
Siblings							
Grandfather							
Grandmother							
Other							

How Many Siblings do you have   Brothers____   Sisters _____

How many Children do you have   Sons _____   Daughters ____

Social History

Occupation: ____

Marital Status ___ Married ___ Divorced ___ Widowed ___ Single

Do you have any Children ___Yes ___ No If so, How Many ____

Do you or have you ever smoked tobacco products? ____ Yes ____ No If so, what type? _____________________________

Number of years smoked? ___________ How much per day? ___________ Year Quit? __________________________________

Do you regularly drink alcohol? ____ Yes ____ No If so, How much per day? _______________________

Do you currently use illegal drugs? ____ Yes ____ No If so, What Type? ______________________________

Do you have a history of substance abuse ____ Yes ____ No If so, What Type? _______________________________

Patients OVER 50 Years Old:

Please provide us with the last date of your test of immunization?

Colonoscopy Date: __________________

Flu Shot Date: __________________

Pneumonia Shot Date: __________________

Tetanus Shot Date: __________________

Women's Health

Date of Last Period: ___________________________

Date of Last Pap Smear: ________________________

Was last Pap Smear Normal ___ Yes ___ No

Date of Last Mammogram: ______________________

Have you ever been pregnant? ____ Yes ___ No

If yes, Number of Pregnancies? _____________ Number of Births: _________

PATIENT PORTAL
AND
NEW POLICY REGARDING MISSED APPOINTMENTS

MISSED APPOINTMENTS

Effective January 1, 2015

We are dedicated to helping our patients and appreciate those who value this dedication of time. We receive calls from patients who are sick and need to be seen that same day and often our schedule is full. Last minute cancellations and no show affect other patients.

Therefore, effective January 1, 2015
all no-show/missed appointment will result in a $25.00 fee.

Patient Signature ________________________________ Date: _______________

Patient Portal

Patient Portal: This will be where you will be able to see lab results, appointments reminders, request refills, schedule appointments, view your visit summary, view your financial statements and contact staff.

E-Mail Address: ____

Please initial that you have read and understood the policies of Pachie Chan M.D. PLLC (PCMD).

Consent to Medical Treatment

__________ (Please Initial) I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services, which may include diagnostic procedures and such medical treatment by the physician and/or assistants. I also consent to the taking of photographs and understand that such photograph is part of the medical record I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to results of treatment or examination at PCMD. I understand by signing this form, I am giving permission to the doctors, nurses, and other health care providers in this medical office to provide treatment as long as a physician/patient relationship exists, or until I withdraw my consent.

Sharing Records for Treatment

__________ (Please Initial) we share medical records electronically with other health care providers to allow and promote continuity of care among providers. By initialing below, you consent to your records being forward to your other doctors for treatment.

Electronic Prescriptions

__________ (Please Initial) we send prescriptions by E-prescribing and also pull history of past Medications, which allow Dr. Chan to pull and submit electronically by transmit prescriptions to the pharmacy of your choice. By initialing, you agree to authorize E-prescription to be sent on your behalf.

Acknowledgement: Notice of Privacy Practices

__________ (Please Initial) I have had the chance to review the PCMD privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the privacy practices.

Financial Agreement and Statement of Responsibility

__________ (Please Initial) I agree to pay PCMD for all services and charges. I understand that I am responsible for any health insurance deductibles, coinsurance and non-covered charges. Payment in full is due at time services are rendered or payment arrangements are to be made before your appointment.

MEMORIAL HERMANN INFORMATION EXCHANGE (MHiE)

The MHie is a health information exchange network developed by Memorial Hermann Healthcare System. Exchange Members include hospitals, physicians and other healthcare providers. Exchange Members are able to share electronically medical and other individually identifiable health information about patients for treatment, payment and healthcare operation purposes. We are an Exchange Member of the MHiE and we seek your permission to share your health information with other Exchange Members vis MHiE. By executing this form, you consent to our use and electronic disclosure of your health information to other MHie Exchange Members for treatment payment and healthcare operation purposes. We will not deny you treatment or care if you decline to sign this consent, but we will not be able to electronically share your health information with your healthcare providers that participate in the MHiE as Exchange Members if you do not sign this consent.

INFORMATION THAT WILL BE DISCLOSED: PURPOSE OF THE CONSENT FOR DISCLOSURE

I hereby consent to disclosure of my medical, health and encounter information by any and all Memorial Hermann Healthcare Systems providers to other participation providers in the MHiE who may request such information for treatment, payment of healthcare operation purposes. I understand the information to be disclosed includes medical and billing records used to make decisions about me.

I HEREBY SPECIFICALLY AUTHORIZE PROVIDER TO RELEASE ALL TYPERS AND CATEGORIES OF PORTECTED HEALTH INFORMATION TO OTHER HEALTHCARE PROVIDERS THAT PARTICIPATE IN THE MHiE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION PURPOSES, (INCLUDING BUT NOT LIMITED TO, YOUR ALCOHOL AND TREATMENT RECORDS, YOUR DUG ABUSE TREATMENT REOCRDS. YOUR MENTAL HEALTH RECORDS, AND YOUR HIV/ACQUIRED IMMUNE DIFICIENCY SYNDROME REOCRS, AS APPLICABLE)

No Conditions: This Consent is voluntary. We will not condition your treatment on receiving this Consent. HOWEVER, IF YOU DO NOT AGREE TO THIS CONSENT YOU CANNOT PARTICIPATE IN THE MHiE.

Effect of Granting this Consent: This consent permits all MHiE members to access your health information. Exchange members of MHiE are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indication and authorized herein.

Term and Revocation

This Consent will remain in effect until you revoke it. You may revoke this consent at any time by completing the MHiE notice of revocation. The MHiE notice of revocation is available by calling 713-456-6443. Revocation of this consent will not affect any action we took in reliance on this consent before we received your notice of revocation. Revocation of this consent will also have no effect on your personal health information made available to Exchange Members during the timeframe in which your consent was active.

I have had full opportunity to read and consider the contents of this consent. I understand that, by agreeing to this consent, I am confirming my consent and authorization of the use and or disclosure of my personal health information.

____ ________________________ ______________

Patient name Date of Birth Date

PACHIE CHAN M.D. PLLC
TELEMEDICINE CONSENT

Introduction. Telemedicine involves the real-time evaluation, diagnosis, consultation on, and treatment of a health condition using advanced telecommunications technology, which may include the use of interactive audio, video, or other electronic media. As such, telemedicine allows the provider to see and communicate with the patient in real-time.

Consent for Treatment. I voluntarily request Pachie Chan M.D. PLLC physicians/NP/PA and such associates, residents, technical assistants and other health care providers as they may deem necessary ("Pachie Chan M.D. PLLC Telemedicine Providers") to participate in my medical care through the use of telemedicine.

I understand that Pachie Chan M.D. PLLC Telemedicine Providers (i) may practice in a different location than where I present for medical care, (ii) may not have the opportunity to perform an in-person physical examination, and (iii) rely on information provided by me. I acknowledge that Pachie Chan M.D. PLLC Telemedicine Providers' advice, recommendations, and/or decision may be based on factors not within their control, such as incomplete or inaccurate data provided by me or distortions of diagnostic images or specimens that may result from electronic transmissions. I acknowledge that it is my responsibility to provide information about my medical history, condition and care that is complete and accurate to the best of my ability. I understand that the practice of medicine is not an exact science and that no warranties or guarantees are made to me as to result or cure.

If Pachie Chan M.D. PLLC Telemedicine Providers determine that the telemedicine services do not adequately address my medical needs, they may require an in-person medical evaluation. In the event the telemedicine session is interrupted due to a technological problem or equipment failure, alternative means of communication may be implemented, or an in-person medical evaluation may be necessary. If I experience an urgent matter, such as a bad reaction to any treatment after a telemedicine session, I should alert my treating physician and, in the case of emergencies dial 911, or go to the nearest hospital emergency department.

Release of Information. To facilitate the provision of care and/or treatment through telemedicine, I voluntarily request and authorize the disclosure of all and any part of my medical record (including oral information) to Pachie Chan M.D. PLLC Telemedicine Providers. I understand and agree that the information I am authorizing to be released may include: 1) AIDS/HIV test results, diagnosis, treatment, and related information: 2) drug screen results and information about drug and alcohol use and treatment; 3) mental health information; and 4) genetic information.

I understand that the disclosure of my medical information to Pachie Chan M.D. PLLC Telemedicine Providers, including the audio and/or video, will be by electronic transmission. Although precautions are taken to protect the confidentiality of this information by preventing unauthorized review, I understand that electronic transmission of data, video images, and audio is new and developing technology and that confidentiality may be compromised by failures of security safeguards or illegal and improper tampering.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents.

____ ________________

Signature of Patient/Responsible Party (Relationship to Patient) Date

Pachie Chan M.D. PLLC
Financial Policy Agreement

Thank you for choosing Dr. Chan for your family's medical care. We are committed to providing you with quality personal health care. As a part of our professional relationship, it is important you understand our financial policy. Other than for true medical emergencies, agreement with this policy is required for all medical care.

Payments

Cancellation/No Show Policy

- While understanding there may be times when you miss an appointment due to emergencies or obligations, our office requires at least 24 hours prior notice on all canceled appointments to avoid a fee of $25.00.

Prescription Refill Policy (without a scheduled appointment)

- New prescriptions will not be issued without seeing Dr. Chan
- Renewed prescriptions may require an office visit before further prescriptions are authorized.
- Any narcotic prescriptions require some visit every 90 days.

Patient Balance Policy

- Pachie Chan M.D after filing with insurance companies will mail you a Patient Balance Statement. Payment in full is due upon receipt of this statement. If you have any questions or dispute the balance it is your responsibility to contact the billing office within 30 days. Past due accounts will be subject to a 5% monthly late fee (minimum of $5.00 per month) and may be referred to a collection agency.
- If you are not able to pay your balance 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.

Request for medical records, Letter, or Forms

- A written request must be provided for any release of medical records. Medical record Fee of $25.00 must be collected before records can be sent out.
- Letters requiring medical review and physician signature are subject to a $15.00 fee. Some letters may require a doctor's visits to complete.
- Any forms including FMLA requires a doctor's appointment before they can be completed.

Insurance

While the filing of insurance claims is a courtesy we extend to our patients, it is your responsibility to:

1. Bring your valid and up-to-date proof of insurance coverage and a driver's license to each appointment.
2. Complete Patient Information Form at each visit
3. Notify our office of any changes to your insurance.
4. Be familiar with your co-pay and be prepared to pay at each visit.
5. Determine if Physicians are network providers prior to your visit.
   It is your responsibility to know coverage of your plan. Although we check benefits there is never a guarantee of payment.

6. We participate in most managed care plans and will file your insurance plan as may be necessary; however, patients are required to pay for their portion of their health plan benefits at the time services are provided.
7. If correct insurance information was not given to us, you as the patient will be responsible for the balance.

Co-Payments and Deductible Policy

- All co-payments, current balances are due and payable PRIOR to services being rendered and is required by your insurance to be paid at each visit. Patients who do not have their copayment may have their appointment rescheduled.
- Deductibles and co-insurance are due and payable at checkout after services provided on the day of service.
- All Co-payments and unsatisfied deductibles must be paid at the time of service. By contractual law your insurance company requires us to charge for, and you to pay for, all required co-payments, co-insuances, deductibles and non-covered services.

Claim Submission

- We will submit your insurance claim and assist you in any way reasonable to help get our claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to comply with their request in a timely manner. Texas insurance law requires your insurance company to provide timely payment. Please be aware that the balance of your claim is your responsibility to pay whether your insurance company has paid.

Cash Pay

- We require a $90.00 up front payment before your physicians visit and $120.00 for a new patient.
- **Any additional services will be additional fee i.e.: ekg, urinalysis, shot, etc.**

Thank you for understanding our payment policy. Please let us know if you have any concerns.

FINANCIAL POLICY

PACHIE CHAN M.D. PLLC believes that communicating our financial policy is good healthcare practice. Charges incurred for services rendered are the patient's responsibility regardless of insurance coverage. Your insurance coverage is a contract between you and your insurance company, not your insurance company and us. We will file your primary and secondary insurances as a courtesy. Please realize that having secondary insurance does not necessarily mean that your services are covered 100%. Secondary insurances typically pay according to a coordination of benefits with the primary insurance. It is your responsibility to provide us with accurate insurance information and to inform us of any changes in your coverage as they occur. You are responsible for all copays, coinsurance, deductibles, and non-covered services. We are obliged to collect your copay at the time of service per your insurance company. We accept cash, debit card, MasterCard & Visa. Statements are sent out monthly, and we ask that balances due be paid when you receive your statement or at your next appointment, whichever is sooner. Patient payments are typically applied to the oldest balances first, except for copayments and coinsurances – they are applied to the current date of service. There is a $25.00 bounced check service charge. Payment will then need to be made by cash, money order or credit card for the balance due. When you receive healthcare services from us and we bill your insurance, it is the same as though we are extending you credit. You receive the service and we await payment from you and/or your insurance. Due to the high cost of rendering care and the lowering reimbursements by many insurers, including Medicare, we simply cannot afford to carry large balances. Balances not paid within 90 days will be turned over to an outside collection agency, unless prior payment arrangements have been made and of course a service fee will be generated. Some patients may accrue large balances for services provided. We will work with these patients to set up a mutually feasible payment plan. In some cases, if the minimum payment due cannot be paid, we will need proof of financial hardship. Please understand that we cannot waive deductibles, coinsurances or copays that are required by your insurance. This is a violation of our contracts with the insurance plans.

I understand and agree to Pachie Chan M.D. PLLC Financial Policy.

Print Name____ Date____________________________

Signature____