REGISTRATION FORM

(PLEASE PRINT)

Today's Date:	Referring Doctor:

PATIENT INFORMARTION

Patients Last Name: First: Middle:	Mr. Mrs. Miss Ms.	Marital Status: Single Mar. Div. Sep. Wid.

Is this your legal name? Yes No	If not, what is your legal name?	Former maiden name	Sex: F M N/A	DOB:
Address:		Social Security:	Phone:	
PO Box:	City:	State:	Zip:	
Occupation:	Employer:	Employer Number:		
Race: Caucasian/white African American Chinese Filipino Japanese Korean Vietnamese Other Pacific Islander Mexican Other Spanish Other: _____		Language: English Spanish Other: _____	Interpreter Needed: Yes No	

EMERGENCY CONTACT

Name of contact:	Relationship to patient:	Primary phone:	Work phone:

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 **Teng Medical Foundation PC** or insurance company to release any information required to process my claim(s).

_____ PATIENT/GUARDIAN SIGNATURE

_____ DATE

Jane Chunwen Teng, D.O., M.Sc

871 Sterling Parkway, Suite 100

Lincoln, CA 95648

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 of services provided.

Before your appointment, please review your insurance information regarding its policies on, copayments, coinsurances and deductibles, which may be required. Office appointments are to be paid for at the time services are provided. This includes copayment, coinsurances 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 complaints 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 test performed.

Payment for services can be made by cash, or credit/debit card including; MasterCard and Visa. **Patient or responsible party will be charged $25 for any returned check.**

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 $35.

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

Patient Name: _____

Patient Signature: _____

Date: _____

Please see back side

Jane Chunwen Teng, D.O., M.Sc

871 Sterling Parkway, Suite 100

Lincoln, CA 95648

Co-payment and/or co-insurance is due at the time of service. At each visit, please be prepare 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 have 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 have any questions, you may contact the billing department at +1(510)259-0000. The billing office is always willing to answer any billing questions you may have.

I understand the I am financially responsible for all charges whether or not they are covered by 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.

Signature:_____ Date: _____

Annual Physical vs Problems Focused Visit

Annual Physical

(Preventive Care or Wellness Visit)

Visit focused on preventative care and general health status

Annual Physical Exam Include:

- Health history review
- Medication review
- Lab review
- Preventative screening
- Detailed physical exam

Wellness only visits are typically copay exempt

Problem Focused Visit

(Office Visit, Sick Visit or Follow Up)

Visit to evaluate and manage new or existing medical conditions

Focused Visit 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
    - Copay and deductible will apply

I have read and understand the difference between annual physical exam 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.

_____ **Date** _____

Signature of patient or legal representative

Jane Chunwen Teng, D.O.,M.Sc.

STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH CARE SERVICES
PRIVACY OFFICE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize _____ to
(Name of patient) (Name of person or facility which has information)

release the following health information: all medical records

To:

Teng Medical Foundation
(Name and title or facility name to receive health information)

871 Sterling Pkwy, suite 100, Lincoln, CA 95648 (Street address, city, state, ZIP code)

916-253-9898 (Telephone number)

916-209-3139 (Fax number)

For the following purposes: patient care

This authorization is in effect until no expire (date or event), when it expires.

I understand that by signing this authorization:

- ☐ I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- ☐ I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- ☐ I have the right to receive a copy of this authorization.
- ☐ I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- ☐ I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Signed by Patient:	Date
Or Signed by Personal Representative: _____ On Behalf of _____ Name of Patient	Date

Teng Medical Foundation, P.C.

Notice of Privacy Practices Acknowledgement Form

I understand that, under the Health Insurance Portability & Accountability Act of 1998 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____