QUY LE MD
GENERAL AND COLORECTAL SURGERY

Registration Form

Patient Information

Last Name	First Name	MI	Birth Date
Address	City	State	Zip

Please ✓ Primary Phone	☐ Home Phone	☐ Work Phone	☐ Cell Phone
Gender ☐ M ☐ F	SSN	Preferred Language	Driver's License

Marital Status	**Preferred Contact**	**Ethnicity**	**Race**
☐ Married	☐ Mail	☐ Vietnamese	☐ American Indian or Alaskan Native
☐ Single	☐ Home Phone	☐ Filipino	☐ Asian
☐ Divorced	☐ Day Home	☐ Cambodian	☐ Black or African American
☐ Separated	☐ Cell Phone	☐ Hispanic/Latino	☐ Native Hawaiian / Other Pacific Islander
☐ Widowed	☐ Patient Portal (My Chart)	☐ Non-Hispanic	☐ Caucasia
☐ Life Partner			☐ Other

Email Address	**PCP**	**Referring Physician**

Responsible Party (Guarantor) ☐ *Same as Patient*

Last Name	First Name	MI	Birth Date
Address	City	State	Zip

Please ✓ Primary Phone	☐ Home Phone	☐ Work Phone	☐ Cell Phone
Relationship to Patient	SSN	Preferred Language	Driver's License

Emergency Contact (for minor child, this section may be used for other parent)

Last Name	First Name		
Address	City	State	Zip

Relationship to Patient	☐ Home Phone	☐ Work Phone	☐ Cell Phone

*I/We do hereby consent to and authorize all treatments, surgeries, and medical services deemed advisable by the physician and staff of **Quy V. Le, MD, Inc** to me or the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am financially responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I am aware that there will be a **$25** fee for any returned payments. I also hereby authorize release of my medical information for the process of insurance benefits for any medical or surgical services rendered.*

_____ _____

Signature of Patient/Responsible Party Date

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Patient Medical History

Patient Name _____ **DOB** _____

Pharmacy Information – Preferred Pharmacy			
Pharmacy Name			
Address			
Phone		Fax	

Medications – List all medications you take, prescription and non-prescription and the dosage

□ **I do not take any medications**

Medication Name	Dosage

Medication and Food Allergies – List all known allergies (drugs, food, animals, etc.)	□ **No Known Allergies**

Medical History – Check if you have ever experienced the following conditions.			□ **None**
□ Abdominal Pain	□ Crohn's Disease	□ Hepatitis A/B/C	□ Pancreatitis
□ Anemia	□ Depression	□ High Blood Pressure / Hypertension	□ Nerve/Muscle Disease
□ Anxiety	□ Diabetes	□ High Cholesterol / Hyperlipidemia	□ Osteoporosis
□ Asthma	□ Diverticulitis	□ HIV / AIDS	□ Peptic Ulcer Disease
□ Blood Clots	□ Gallbladder Disease	□ Incontinence	□ Prostate Disease
□ Coronary Artery (CAD)	□ GERD (Reflux)	□ Irritable Bowel Disease	□ Renal/Kidney Disease
□ Cancer - Type	□ Headaches / Migraine	□ Kidney Stones	□ Seizure
□ Chest Pain	□ Heart Disease / Problem	□ Liver Disease	□ Thyroid Disease
□ COPD (Emphysema)	□ Hemorrhoids	□ MI (Heart Attack)	□ **Other**

Surgical History – Check if you have received the following procedures.			□ **None**
□ Angioplasty	□ Hernia Repair	**Male ONLY**	
□ Appendectomy	□ Liver Biopsy	□ Prostate Biopsy	□ Vasectomy
□ Cholecystectomy	□ Pacemaker	□ **Other**	
□ Colectomy	□ Small Bowel Resection	**Female ONLY**	
□ Colostomy	□ Thyroidectomy	□ Breast Biopsy or Surgery	□ Hysterectomy
□ Heart Bypass	□ **Other**	□ **Other**	

Family History – Fill in any family member(s) with the following conditions.			□ **Adopted**
□ Alcoholism		□ Cancer – Type	
□ Allergies		□ Diabetes	
□ Asthma		□ Heart Condition	
□ Blood Disorder		□ Hyperlipidemia	
□ Hypertension		□ Stroke	
□ **Other**			

Social History – For Adult Patient		
Occupation / Job:		Employer Name:
How often?		**What type?**
Tobacco □ Yes □ No		□ Chewing □ Cigar □ Pipe □ Cigarette □ Smokeless
Alcohol □ Yes □ No		□ Beer □ Liquor □ Wine □ Other
Substance □ Yes □ No		□ Cocaine □ Heroin □ Marijuana □ Opium □ Other

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Patient Name _____DOB _____

ASSIGNMENT OF INSURANCE BENEFITS AND ELIGIBILITY

Primary Insurance Plan		
Insurance Plan Name	Group #	Policy #
□ Medicare □ PPO □ POS □ EPO □ HMO (Please enter Medical Group Name)		
Subscriber Name	Subscriber Date of Birth (if not the patient)	
Relationship to Patient		

Other Insurance Coverage for Patient (Secondary Insurance)		
Insurance Plan Name	Group #	Policy #
□ Medicare □ PPO □ POS □ EPO □ HMO (Please enter Medical Group Name)		
Subscriber Name	Subscriber Date of Birth (if not the patient)	
Relationship to Patient		

_____ ***(initial)*** I hereby authorize, and request payment of my insurance benefits to be paid directly to **Quy V. Le, MD, Inc.** for any medical or surgical services rendered. I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its agents or carriers, or the insurance company any information needed for this or a related insurance claim to determine these benefits or the benefits payable for related services. I understand that it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment. I understand that I am financially responsible for charges regardless of insurance benefits. I am also responsible for collection, legal, or any other cost incurred, should this be necessary on my account because of non-payment. I am aware that there will be a **$25** fee for any returned payments.

ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices & Consent for Use & Disclosure of Personal Health Information

_____ ***(initial)*** Your name and signature on this form indicates that you have received a copy of our office's ***Notice of Privacy Practices*** or that it was made available to you to receive.

_____ ***(initial)*** Your signature below indicates your consent to the use and disclosure of your personal health information by our office for treatment, billing, payment, and health care operations as outlined in the ***Notice of Privacy Practices.***

_____ ***(initial)*** If you have any questions regarding the information contained in this ***Notice of Privacy Practices,*** please speak with one of our staff or contact our office at (714) 200-1499.

_____
Sign Acknowledgement

_____ _____
Signature of Patient / Responsible Party Date

_____ _____
Name of Patient / Responsible Party (please print) Relationship to Patient

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Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company, we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient /Responsible Party Date of Birth

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient

_____

Date