Alliance Retina

THÔNG TIN BỆNH NHÂN

Họ và tên bệnh nhân:			Tình trạng hôn nhân:		
Tên gọi trước đây:			Ngày sinh:	Tuổi:	Giới tính: ☐ Nam ☐ Nữ
Địa chỉ hiện tại:			Thành phố:		Zip code:
Số An sinh Xã hội:	Điện thoại nhà:		Điện thoại di động:		
Nghề nghiệp:	Nơi làm việc:		Điện thoại công sở:		
Địa chỉ e-mail:					

Dân tộc: (thông tin bắt buộc theo luật liên bang HIPAA)

☐ American Indian or Alaskan Native
☐ Châu Á
☐ Black or African American
☐ Hispanic
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Không biết

TRONG TRƯỜNG HỢP KHẨN CẤP

Tên người liên lạc khẩn cấp:	Mối quan hệ:	Điện thoại 1:	Điện thoại 2:

THÔNG TIN NHÀ THUỐC

Tên:	Phone:
Địa chỉ:	Fax:

THÔNG TIN BÁC SĨ GIA ĐÌNH

Tên:	Thành phố:	Phone:
Địa chỉ:		Fax:

THÔNG TIN BÁC SĨ MẮT

Tên:	Thành phố:	Phone:
Địa chỉ:		Fax:

THÔNG TIN BÁC SĨ GIỚI THIỆU

Tên:	Thành phố:	Phone:
Địa chỉ:		Fax:

Alliance Retina

THÔNG TIN BẢO HIỂM CHÍNH

(vui lòng mang theo thẻ bảo hiểm và đưa cho nhân viên tiếp tân)

Tên Công ty Bảo hiểm chính:	Ngày hiệu lực:	
Người đứng tên bảo hiểm:		Ngày sinh:
Số An sinh Xã hội:	Mối quan hệ giữa bệnh nhân và người đứng tên bảo hiểm:	
Số nhóm bảo hiểm:	Số hợp đồng bảo hiểm:	Số tiền đồng thanh toán: $

THÔNG TIN BẢO HIỂM PHỤ

Tên Công ty Bảo hiểm phụ	Ngày hiệu lực:	
Người đứng tên bảo hiểm:		Ngày sinh:
Số An sinh Xã hội:	Mối quan hệ giữa bệnh nhân và người đứng tên bảo hiểm:	
Số nhóm bảo hiểm:	Số hợp đồng bảo hiểm:	Số tiền đồng thanh toán: $

THÔNG TIN VỀ QUYỀN LỢI TRỢ CẤP TAI NẠN LAO ĐỘNG
(chỉ điền thông tin nếu bị tai nạn lao động)

Tên người sử dụng lao động tại thời điểm tai nạn:	Ngày bị tai nạn:
Địa chỉ:	Phone:
Tên công ty bảo hiểm thanh toán:	Phone:
Địa chỉ công ty bảo hiểm:	
Số hồ sơ yêu cầu thanh toán bảo hiểm:	Tên người điều chỉnh:

Alliance Retina

KIM-BINH MAI, MD
VITREORETINAL SURGERY AND DISEASES

Họ tên người bệnh: **Ngày:**

BẢNG TÓM TẮT TIỀN SỬ BỆNH

Cơ quan Quản lý Tài chính Y tế yêu cầu chúng tôi thu thập thông tin về tiền sử bệnh theo hướng dẫn của Cơ quan này cho mục đích tham vấn thanh toán. Nếu quý vị có thắc mắc hoặc cần hỗ trợ liên quan đến mẫu thông tin này, vui lòng liên lạc với nhân viên của chúng tôi.

Quý vị đang gặp vấn đề hay triệu chứng gì liên quan đến thị lực?

Vui lòng liệt kê tất cả bệnh hoặc thương tật quý vị từng bị:

Vui lòng liệt kê tất cả cuộc giải phẫu (bao gồm giải phẫu mắt) quý vị từng trải qua:

Vui lòng liệt kê tất cả tên và loại thuốc (bao gồm thuốc về mắt) mà quý vị sử dụng:

Vui lòng liệt kê tất cả các dị ứng mà quý vị có:

Quý vị có đang gặp phải vấn đề sức khoẻ nào liệt kê bên dưới không?

Da liễu	☐ CÓ	☐ KHÔNG	☐ CÓ	☐ KHÔNG	Thần kinh
Tai Mũi Họng	☐ CÓ	☐ KHÔNG	☐ CÓ	☐ KHÔNG	Hạch bạch huyết
Hô hấp (phổi)	☐ CÓ	☐ KHÔNG	☐ CÓ	☐ KHÔNG	Bệnh máu
Tim mạch	☐ CÓ	☐ KHÔNG	☐ CÓ	☐ KHÔNG	Dị ứng / Miễn dịch
Dạ dày - Ruột	☐ CÓ	☐ KHÔNG	☐ CÓ	☐ KHÔNG	Sinh dục
Cơ - Xương - Khớp	☐ CÓ	☐ KHÔNG			

Quý vị có uống rượu bia không? ☐ CÓ ☐ KHÔNG

Quý vị có hút thuốc không? ☐ CÓ ☐ KHÔNG

Quý vị có dùng thuốc làm loãng máu không? ☐ CÓ ☐ KHÔNG

Nếu có, tên thuốc quý vị đang dùng: ____

Quý vị có nghĩ mình có nguy cơ bị nhiễm HIV không? ☐ CÓ ☐ KHÔNG

____

Chữ ký người bệnh / người giám hộ

KIM-BINH MAI, MD
VITREORETINAL SURGERY & DISEASES

WRITTEN ACKNOWLEDGEMENT FORM

I, ___________________________________ (Please print patient name) have been provided a copy of Alliance Retina's Notice of Health Information Practices and Notice of Financial Policy.

I have had an opportunity to read the Notice of Health Information Practices and Notice of Financial Policy.

I understand that at I may ask question if I do not understand any information contained in the Notice of Health Information Practices and Notice of Financial Policy.

____ ______________

Patient/Guardian Signature Date

____

Patient/Guardian Printed Name

NOTICE OF FINANCIAL POLICY

Please read and sign the following financial policy summary. If you have questions about this Financial Policy, please contact our office at 817-617-7678.

1. Payment is due in full at the time services are rendered. We accept cash, check, and all major credit cards. Post-dated checks will not be accepted by our office.
2. Please be prepared to provide our office with a copy of your insurance card(s) and picture identification every time you visit our practice. Each time you visit our office you may be required to update your personal information such as home address, contact phone numbers, and emergency contact phone numbers. If there are any changes in your insurance, it is your responsibility to notify our office prior to your visit. If the new insurance information is not provided prior to the visit, you could be responsible for charges incurred for any dates of service or treatments prior to the new information being given.
3. If your insurance requires you to pay a co-pay, then you must pay this co-pay at the time of your appointment. Your visit or treatment may be rescheduled if prior authorization from insurance or PCP is required. Payment of unauthorized services is then your responsibility. Fees not covered by your insurance company due to unmet deductibles are due as you leave the office. If this should be the case, we offer payment plans to ensure your treatment does not go unfinished.
4. Physician surgical fees owed are due prior to any surgery performed by the doctor(s) in the various facilities we perform surgery in. This would include any deductible, copay, or coinsurance. Fees quoted by our office for surgery are for the surgeon only. The facility where the operation is performed is responsible for quoting and collecting payment for their fees. It is your responsibility to contact the surgery facility to obtain their fees and make payment arrangement prior to the date of surgery.
5. Financial responsibility for a minor is the responsibility of the accompanying adult unless arrangements have been made prior to the visit.
6. Any PAST DUE BALANCE is required to be paid either by the statement received from our billing office or at the time of your next visit. In the event your account is past due, we will take the necessary steps to collect the debt, and possible referral to a collection agency which could affect your credit record.
7. SELF PAY/CASH PAY POLICY: For patients who are using cash for their office visit, a $300 deposit will be due at the time of service. This is a discounted rate for a new visit which included a dilated fundus ophthalmoscopy and a basic diagnostic optical coherence tomography.
8. INSURED PATIENTS WITH UNMET DEDUCATIBLE: For patients who have not met their insurance deductible, a $300 deposit will be due at the time of service. This deposit will be applied to the actual charges for the visit. If the visit charges exceed $300, the remaining balance will be billed to you. In the event the actual charges are less than $300, the difference will be refunded within 10 days.
9. A $25.00 return check fee will be assessed if your check is returned by your bank.
10. Due to the amount of support services associated with FMLA and other paperwork, we may charge $25.00 for its completion.

KIM-BINH MAI, MD
VITREORETINAL SURGERY & DISEASES

NOTICE OF HEALTH 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.

USES AND DISCLOSURES

TREATMENT. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluation your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

PAYMENT. Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

HEALTHCARE OPERATIONS. Your health information may be used as necessary to support the day-to-day activities and management of Alliance Retina of Texas PLLC. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

LAW ENFORCEMENT. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

PUBLIC HEALTH REPORTING. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purposes other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes when financial remuneration is involved. We may not sell your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

ADDITIONAL USE OF INFORMATION

APPOINTMENT REMINDERS. Your health information will be used by our staff to send you appointment reminders.

INFORMATION ABOUT TREATMENTS. Your health information may be used to send you information on the treatment and management of your medical condition that you may find interesting. We may also send you information describing other health related products and services that we believe may interest you.

FUNDRAISING. We will not use your protected information for fund-raising efforts unless approved by you in writing for the specific fund-raising effort.

MARKETING. We will not use your protected information for marketing efforts unless approved by you in writing for the specific marketing effort.

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect a copy of your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

ALLIANCE RETINA OF TEXAS PLLC'S DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices outlined in this notice. In the event of a breach of unsecured protected information, if your information has been compromised, it is our duty to notify you.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit.

The revised policies and practices will be applied to all protected health information we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to you records by contacting our Medical Records department or the Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

COMPLAINTS

If you would like to submit a comment or complain about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
Alliance Retina of Texas PLLC
1007 W. Randol Mill Road Suite 110
Arlington, TX 76012

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filling a complaint.

The effective date of this Notice is 07/10/2017.