Scott Liang, M.D., Inc.

4153 E Live Oak Ave, Arcadia, CA 91006, Tel 626-628-0808, Fax 626-628-0809, www.drscottliang.com

REGISTRATION FORM (PAGE 1)

(Please Print)

Welcome to our medical clinic! It is our pleasure to serve you!	Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) ☐ Single / ☐ Mar / ☐ Div / ☐ Sep / ☐ Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Home phone no.:

City, State	Zip code:	Mobile Phone: E-mail address:

Occupation:	Employer: Name of Spouse:	Work Phone: Spouse Mobile:

Referred by (please check any that apply and fill in info:	☐ Family, Name_____	☐ Insurance Plan	☐ Hospital

☐ Zocdoc	☐ Yelp	☐ Google	☐ Dr._____	☐ Other_____	☐ Friend, Name:_____

Driver's License No:	Name of other family members seen here:

INSURANCE INFORMATION

Must be filled out by patient or representative AND please give all insurance cards and IDs to the receptionist.

Person responsible for bill:	Birth date:	Address (if different):	Home phone: Mobile phone:

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	**Subscriber ID:**	Work phone:

Please indicate primary insurance	☐ Medicare	☐ Blue Cross	☐ Blue Shield	☐ Health Net	☐ Allied HMO

☐ United Healthcare	☐ Aetna	☐ Tricare	☐ Optum HMO	☐ Other _____

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:		Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Subscriber ID:	Group no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone:	Mobile phone:

The above information is true to the best of my knowledge.

Patient Name _____

Patient/Guardian signature _____ Date _____

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REGISTRATION FORM (PAGE 2)

INSURANCE:

- I authorize that my claims be sent to the insurance I provided, and my insurance benefits be paid directly to the physician. Initial _____

- I understand that I am financially responsible for any non covered service, balance, deductible and co-pay. Initial _____

- I also authorize Scott Liang, M.D., Inc. or insurance company to release any information required to process my claims. We will bill the patient provided insurance, however if denied, it will be the patient's responsibility to resolve. Initial_____

- The practice will attempt to verify active coverage for the date of service; however it is NO GUARANTEE that the insurance will cover that service. Initial_____

- It is the patient's responsibility to find out the actual coverage and will be responsible should the service not be covered. Initial_____

- **NEW PATIENTS ONLY: First visits will be billed as new patients, NOT AS PHYSICALS. Physicals may only be scheduled for established patients. New Patient Initial _____**

Please sign here that the Insurance Policy is acknowledged and accepted.

Name _____Date:_____

PATIENT BALANCES OR INSURANCE NON COVERED SERVICES:

- Any balance that falls over 30 days may be subject to a $30 late fee. Please contact our office immediately so that payment options can be worked out and late fee avoided. Initial_____

- Should the patient fall delinquent past 60 days, any and all means will be utilized to collect, up to and including late fees and forwarding to a COLLECTION AGENCY. Initial_____

Please sign here that the Patient Balance policy is acknowledged and accepted.

Print Name of Responsible Party_____

Patient/Responsible Party signature *Date*

_____ _____

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REGISTRATION FORM (PAGE 3)

Name: _____ Date:_____

CONFIDENTIAL PATIENT RECORDS

Personal Medical History (Please list all medical diagnoses)		

Personal Surgical History (Please list all prior surgery and date of surgery)		

Family History (Please list known conditions of family members)
Mother:
Father:
Siblings:
Maternal Grandparents:
Paternal Grandparents:
Other:

Social History	
Smoking? ☐ Packs/day: # years:	Alcohol? ☐ Drinks/week: Concern?
Illicit drug use? (Please list any)	Exercise:

Health Maintenance Screening (Please list test date and known results)		
Cholesterol	Mammogram	
Sigmoid/Colonoscopy	Dexascan	
PSA	Pap smear	
Flu shot	Tetanus/TDAP	Pneumonia Vaccine

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REGISTRATION FORM (PAGE 4)

Name: _____ Date:_____

Medications I am allergic to:	
Pharmacy Name:	Phone Number:
Pharmacy Location:	

Prescription Medications I Take		
Medication Name	Dosage	How Often
1.)		
2.)		
3.)		
4.)		
5.)		
6.)		
7.)		
8.)		
9.)		
10.)		

Over the counter Medications I take		
Medication or Supplement Name	Dosage	How Often
1.)		
2.)		
3.)		
4.)		
5.)		
6.)		
7.)		

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO A DESIGNATED PARTY

Patient Name: _____ DOB:_____ Date:_____

Physician Name: **Scott Liang, M.D.**

Designated party: _____ Designated Party: _____

Relationship to Patient: _____ Relationship to Patient: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

The information will be used or disclosed for the following purposes:

☐ At the request of the individual ☐ Other_____

This Authorization grants permission to the Designated Party (ies) named above to:

☐ have access to my medical record information

☐ have access to my billing & insurance information

☐ have access to any test results

☐ make or confirm appointments

☐ other, please specify_____

I authorize Scott Liang, M.D., Inc. to use and disclose my health information as described in this authorization.

The patient or the patient's representative must read and initial the following statements:

• I understand that this information will: (Must check one)

☐ expire 1 year from the date signed by the patient or patient's representative; or

☐ only when revoked by the patient

• I understand that I may revoke this authorization at any time by notifying in writing the above named Physician Practice at Scott Liang, M.D., Inc.; however, if I do revoke the authorization, it will not have any effect on any actions taken by Scott Liang, M.D., Inc. prior to their receipt of the revocation

• I understand that this authorization is voluntary

• I understand that once this information is released to the Designated Party (ies), the released information may no longer be protected by federal privacy regulations

• I understand that my treatment cannot be conditioned on whether I sign this authorization

_____ _____

Signature of patient or patient's representative Date

(Form MUST be completed before signing or will not be valid) Office of HIPAA Compliance October 2013

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NOTICE OF 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. AS OF 11/01/2010.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the sue and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

PRIVACY PRACTICES ACKNOWLEDGEMENT I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Date of Birth _____/ _____/ _____

Signature_____ Today's Date _____/ _____/ _____

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PATIENT PARTNERSHIP PLAN

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your best possible health requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with Dr. Liang for Routine Physical Exams and Other Recommended Health Screenings
I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears, etc.) These health screenings are tests that can help detect life-threatening diseases and conditions. If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments
I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to Dr. Liang on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests
I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide Not to Follow His or Her Recommended Treatment Plan
I understand that after examining me, my doctor may make certain recommendations based on what he feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his recommendations so that he may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As a patient, you have the right to be informed about your health care. We invite you, at any time to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Sincerely, Scott Liang, M.D.

Patient Name _____ Date of Birth _____/ _____/ _____

Patient Signature_____ Today's Date _____/ _____/ _____

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PATIENT RELEASE OF MEDICAL RECORDS FORM

Patient's Name _____ Today's date:_____

I request and give my permission to release my medical records for the time period dating

from _____ to _____ from the following medical clinic.

_____
(Name of clinic)

_____
(Address)

_____
(City) (State) (Zip code)

_____
(Fax number)

_____
(Comments)

Please send records to Dr. Scott Liang via fax (626) 628-0809 or mail to address above.

_____ _____
(Print patient's name) (DOB)

_____ _____
(Patient's signature) (Date)

This release of medical information is valid for one year after the date it was signed
It is the policy of this medical practice is that we will adopt, maintain, and comply with our notice of privacy practices, which shall be consistent with HIPAA and California law.

revised 2023