YUNG C CHEN, MD
SPINE & MUSCULOSKELETAL MEDICINE * PHYSICAL MEDICINE & REHABILITATION
334 N. SAN MATEO DR., SAN MATEO, CA 94401 * TEL 650-558-1802 * FAX 650-558-1806

PATIENT DEMOGRAPHICS

NAME: _____ **DATE OF BIRTH:** ___/___/_____ **SEX F M**
LAST FIRST MI MO DAY YR

ADDRESS: _____ **SSN:** ____-_____-_____

STREET CITY STATE ZIP

PHONE: _____ | _____ | _____
HOME WORK CELLPHONE

SINGLE MARRIED DIVORCED WIDOWED

EMAIL: _____ **INSURANCE (PRIMARY):** _____ **SECONDARY:** _____

PRIMARY CARE DOCTOR: _____ **ADDRESS:** _____ **PHONE:** _____

EMERGENCY CONTACT NAME: _____ **ADDRESS:** _____ **PHONE:** _____

WORKER'S COMPENSATION INFORMATION

CARRIER: _____ **DATE OF INJURY:** ____/____/_____ **CLAIM #:** _____

ADJUSTOR NAME: _____ **PHONE:** _____ **FAX:** _____

ADDRESS: _____ **EMPLOYER AT TIME OF INJURY:** _____

ATTORNEY NAME: _____ **PHONE:** _____ **FAX:** _____

WORKER'S COMPENSATION DISCLOSURE: I hereby state that this is not a work-related injury, and I realize that my health insurance benefits do not cover services and supplies as a result of an occupational injury.

SIGNATURE: _____ **DATE:** _____

AUTO ACCIDENT INFORMATION

CARRIER: _____ **DATE OF INJURY:** ____/____/_____ **CLAIM #:** _____

ADJUSTOR NAME: _____ **PHONE:** _____ **FAX:** _____

ATTORNEY NAME: _____ **PHONE:** _____ **FAX:** _____

AUTO ACCIDENT DISCLOSURE: I hereby state that this is not an auto-accident related injury, and I realize that my health insurance benefits do not cover services and supplies as a result of a motor vehicle accident.

SIGNATURE: _____ **DATE:** _____

MEDICARE AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Yung Chen for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents the information necessary to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA4 500 Form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agent shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

SIGNATURE: _____ **DATE:** _____

MINOR CONSENT: If the patient is a minor under the age of 18 years old, a parent's or legal guardian's signed consent is required in order to provide treatment.

SIGNATURE: _____ **DATE:** _____

CANCELLATION POLICY: I understand that except in an emergency, I will be responsible to pay full fee for any missed appointments unless cancelled at least twenty four hours in advance. I understand that my insurance does not pay for missed appointments and will not be billed. The fee will be $150 for all appointments except for procedures in which the fee will be $250.

SIGNATURE:_____ **DATE:**_____

Although the staff tries to stay abreast of all insurance information, it is the patient's responsibility to review one's insurance plan's handbook and to know if a second-opinion or pre-certification is necessary as well for what service(s) is covered under one's insurance plan.

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PRIMARY CARE PHYSICIAN: To ensure that every patient receives the best overall medical care, SMSC requires every patient to have a PCP for general health medical care as Dr. Chen is only a specialist in spine/musculoskeletal intervention. It is important for you to have a PCP to monitor your general health. If you don't have one, SMSC can recommend PCPs for you.

My primary care physician is Dr. _____ **Phone #:**_____

Address: _____
STREET CITY STATE ZIP

I understand and acknowledge that Dr. Chen is a spine/musculoskeletal pain interventional specialist and he is **NOT** my internal medicine doctor, or family doctor, or OB/GYN doctor, or primary care physician (PCP). He is **NOT** responsible for my general medical care, such as heart, EKG, lung, gastrointestinal, ear, nose, throat, blood pressure, aneurysm workups, regular blood tests, cholesterol panels, kidney function, liver function, brain or neurological issues. He is **NOT** responsible for cancer screening, cancer workups, or skin, nail, hair care, or infection workups and treatment. He is **NOT** responsible for gynecological reproductive workups, pelvic examinations, breast issues, or hormonal replacements. He is also **NOT** responsible for prostate exams, rectal exams, or testosterone replacement. I will comply to ensure that I have my own PCP for my general medical health condition.

Patient signature:_____ **Date:**_____

NOTICE OF PRIVACY PRACTICE

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. THIS NOTICE IS EFFECTIVE 04/14/03 UNTIL FURTHER NOTICE.

Right to Notice As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPAA), our office can use your protected health information for treatment, payment and health care operations.

a) Treatment - We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
b) Payment - We may use and disclose your health information to obtain payment for services we provide you.
c) Health care operations - We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization
Most uses and disclosures that do not fall under treatment, payment, health care operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Emergency Situations
In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.

Marketing
We will not use your health information for marketing communications without your written authorization.

Required by Law
We may also use or disclose your health information when we are required to do so by law.

Abuse or Neglect
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety.

National Security
We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

Appointment Reminders
We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter.

Your Rights as a Patient
You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or health care operations.
-You have the right to receive confidential communications regarding your protected health information.
-You have the right to inspect and get a copy of your protected health information.
-You have the right to amend your protected health information.
-You have the right to receive an account of disclosures of your protected health information.
-You have the right to a paper copy of this notice of privacy practices.

Legal Requirements
Our office is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted to this site, or are available within our office.

Complaints
If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

I

authorize the following individual(s) listed below to speak with SMSC and may help make my healthcare decisions.
Name(s): _____ Relation(s): _____

I acknowledge that I have received a copy of the above Notice of Privacy Practices (HIPAA) from San Mateo Spine Center.

Patient Name: _____ Signature: _____ Date: _____