North Richardson Family Clinic
PATIENT REGISTRATION INFORMATION

PLEASE FILL IN ALL QUESTIONS AND PRINT CLEARLY Today's Date:_____
Patient SS #_____ Date of Birth:_____
Cell Phone:_____
Patient Name:_____ Home Phone:_____
Work Phone:_____
Patient Address:_____City:_____State:_____Zip:_____

If Minor, Please complete
Parent/Guardian:_____Contact Phone: _____
Relationship to Patient:_____
Address:_____ City:_____ State:_____ Zip:_____
___Male ____Female ____ Single _____ Married _____Divorced ___ Widowed
Patient Employer:_____ Department:_____
Employer Address: :_____City:_____State:_____Zip:_____
Employer Phone Number:_____ Ext:_____
Spouse Information:
Spouse Name:_____ Spouse Contact Phone:_____
Spouse SS #_____ Date of Birth:_____
Employer Name:_____ Work Phone:_____
Cell Phone:_____
Employer Address:_____ City:_____State:____Zip:_____

Person to Contact in Case of Emergency:
Name:_____ Home Phone:_____
Work Phone:_____
Address:_____ City:_____ State:_____ Zip:_____

INSURANCE INFORMATION
Insurance Coverage: _____ Yes _____ No _____ Cash _____ Medicaid ____ Medicare
Is This Workers Compensation / Accident Related: _____ Yes _____ No
Date of Accident:_____ ____ Auto _____ Work _____ Other

PRIMARY COVERAGE
Insured Party: _____ Self _____ Spouse ____ Other/ Relationship_____
Insured Name:_____ Insured SS#:_____
Date of Birth:_____
Insurance Name:_____Policy#:_____
Group#:_____
Insurance Address: :_____ City:_____
State:_____Zip:_____

Insurance Phone Number:_____
Relationship to insured:_____

SECONDARY COVERAGE

Insured Party: _____ Self _____ Spouse ____ Other/ Relationship_____
Insured Name:_____ Insured SS#:_____
Date of Birth:_____

Insurance Name:_____ Policy#:_____
Group#:_____
Insurance Address: :_____ City:_____
State:_____Zip:_____
Insurance Phone Number:_____
Relationship to insured:_____

North Richardson Family Clinic
PATIENT INFORMATION FORM

ALL PROFESSIONAL FEES ARE DUE AT THE TIME OF SERVICE, UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.

Financial Agreement

1. Services are rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance if proper information is received.

    A. You are responsible for co-pays, deductibles, non-covered services, coinsurances and items considered "not medically necessary" by your insurance company.
    B. For unpaid claims over 45 days, it is your responsibility to follow up with your insurance and the balance due is considered due and payable.

2. It is you're responsible to notify our front desk staff of any insurance or address changes.
3. You will be responsible for any charges that occur if we are not notified.
4. Any debt incurred to collect a debt will be at the expense of the patient/responsible party.

Patient Authorization

I authorize Dr. Zhang to submit insurance claims using my signature on file below.
I authorize the release of any medical information necessary in order to process this assignment on the claim. I authorize payment of medical benefits to be paid directly to Dr. Zhang for services describe on the claim form.

_____ _____
Patient Signature (or authorizes representative) Date

I authorize Dr. Zhang to release any medical or billing information necessary, for treatment, payment or healthcare operations to the following family and or friends:(listed names and relationship)

_____
_____
_____

_____ _____
Patient Signature Date

MEDICAL INFORMATION

Date of last complete physical exam _____
List any hospitalizations and date:

_____ _____
_____ _____
_____ _____

FAMILY MEDICAL HISTORY

RELATIVE AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH
FATHER			
MOTHER			
BROTHERS&SISTERS			

Are you allergic to any Medications? Please list all:

_____

Do you smoke?_____ How Much?_____ Did you ever smoke?_____ How much?_____

Do you drink?_____ How Much?_____ Did you ever drink?_____ How much?_____

Do you ever use drugs?_____

Please list any medication you are currently taking including amount per day. Include aspirin, laxatives and cold tablets.

1._____

2._____

3._____

4._____

5._____

Please list any previous medical problems (active or resolved).

_____
_____
_____
_____
_____
_____
_____
_____

North Richardson Family Clinic
Notice of Privacy Practices

Effective Date: ___April 1, 2010___

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED ANDDISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, our policies or practices, please contact the Privacy Officer at
3200 Talon Dr., Suite 100, Richardson, Texas 75082
Phone: (214) 431-4539

Who Will Follow This Notice

This Notice describes our organization_s practices and those of:

- Health care professionals who are members of our workforce authorized to access and/or enter information into your medical record or billing record.
- All departments and units of this practice.
- All employees, volunteers and other practice personnel considered a part of our workforce.
- Any health care entities and medical offices owned by or affiliated with this practice.

Our Pledge Regarding Medical and Billing Information

We understand that information about you and your health is personal. We are committed to protecting medical and billing information about you. We create a record of the care and services you receive at our practice. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, a plan for future care or treatment, and charges or bills for services related to your care. These records are used to provide you with quality care and to comply with certain legal requirements.

This Notice applies to all of the records of your care generated by this practice. You may have a different Notice presented to you, if your care is provided in a facility.

This Notice will tell you about the ways in which we may use and disclose medical and billing information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

We are required by law to:

- Make sure that medical and billing information that identifies you is kept private;

- Give you this Notice of our legal duties and privacy practices with respect to medical and billing information about you; and
- Follow the terms of the Notice that is currently in effect.

How We May Use and Disclose Medical and Billing Information About You

The following categories describe different ways we use and disclose medical and billing information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

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, office staff, or other medical personnel who are involved in taking care of you in our practice.

We may also disclose information about you to other health care providers outside our practice so they may treat you. For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. He may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions, scheduling lab work and ordering x-rays. We may also disclose medical information about you to family members and other health care professionals outside our practice who may be involved in your medical care.This information is shared on the basis of other health care staff _needing to know_ the information about you to provide safe necessary treatment to you.

For Payment: We may use and disclose medical information about you so the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or other third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.
We may also use or disclose your health information to our billing company or consumer

reporting agencies for claims management or collection activities pertaining to the collection of payments owed to us.

For Health Care Operations: We may use and disclose medical information about you for office operation. These uses and disclosures are necessary for patient quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who you or other patients are as individuals. We may provide information about you to other health care providers, health plans, or health care clearinghouses to perform activities such as quality assessment, case management, training and studying groups of people for the purpose of improving health. We may provide information about you to other health care providers, health plans, or health care clearinghouses to perform activities such as quality assessment, case management, training and studying groups of people for the purpose of improving health.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for tests, treatment or medical care.

Treatment Alternatives: We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you or offer you optional care alternatives.

Health-Related Products and Services: We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: Unless you tell us otherwise, we may release medical information about you to a friend or family member who is involved in your medical care. We may give information to someone who helps pay for your care. We may also tell your family or friends your condition and that you are at the practice. In addition, we may disclose medical information about you to an entity assisting us in a disaster relief effort so that your family can be notified about your condition, status and location.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples may include transcription services, billing services or healthcare clearinghouse. When these services are contracted, we may disclose your health information to our business associates so they can perform the jobs we_ve asked them to do

and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to safeguard your information appropriately.

Research: Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who receive one medication to those who received another, for the same condition. In certain circumstances, we are permitted to disclose medical information about you to people preparing for research. For example, researchers may look for patients with specific treatment needs to develop a research protocol, but may not remove the medical information they review from the physician practice. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with Patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the practice.

As Required by Law: We will disclose medical information about you when required to do so by federal, state or local laws.

To Avert a Serious Threat to Health or Safety: We may use or disclose medical information about you when necessary to prevent a serious threat to you health and safety or the health and safety of the public or other person. Any disclosure, however, would only be to someone able to help prevent the threat.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military Personnel: If you are a member of the armed forces, active or reserve, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Worker's Compensation: We may release medical information about you as necessary to comply with laws related to worker_s compensation or similar programs that provide benefits for work-related injuries or illnesses.

Public Health Risks: We may disclose medical information about you for public health activities. These activities generally include the following:

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- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease, or who may be at risk for contracting or spreading a disease or condition; and
- To notify the appropriate government or law enforcement authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. these activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness or missing person;
- About the victim of a crime, if under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the practice; and
- In emergency circumstances to report a crime, the location of the crime or victims, or
- The identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a

deceased person or determine the cause of death. We may also release medical information about you as a patient of the practice to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons and foreign heads of state or to conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Other Uses of Medical Information: Authorization and Right to Revoke Authorization: Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you authorize us to disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required by state law to retain our records of the care that we provide to you.

Your Right Regarding Medical and Billing Information About You

You have the following rights regarding your medical and billing information we maintain.

Right to Inspect and Copy Your Medical and Billing Information: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does **not** include psychotherapy notes.

To inspect and obtain a copy of medical and billing information that may be used to make decisions about you, you must submit your request in writing to

North Richardson Family Clinic
3200 Talon Dr., Suite 100, Richardson, Texas 75082

If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy

this information in certain limited circumstances. If you are denied access to medical or billing information, you may make a request, in writing to the

North Richardson Family Clinic

Privacy Officer, that the denial be reviewed. Another licensed health care professional chosen by the practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend Your Medical and Billing Information: If you feel that medical and billing information we have about you is incorrect or incomplete, you may ask us to amend the information. You have a right to request an amendment for as long as the information is kept by or for the facility. To request an amendment, your request must be made in writing and submitted to

North Richardson Family Clinic

Medical Record Custodian at 3200 Talon Dr., Suite 100, Richardson, Texas 75082

In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing, or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no
- longer available to make the amendment;
- Is not part of the medical or billing information kept by or for the practice;
- Is not part of the information that you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures of Your Medical and Billing Information:
You have the right to request an "accounting of disclosures." This is a list of certain disclosures we made of medical and billing information about you, except for those disclosures to carry out treatment, payment or health care operations, disclosures made to you, disclosures you have authorized or certain other disclosures.

To request an accounting of disclosures, you must submit your request in writing to the North Richardson Family Clinic Privacy Officer. Your request must state a time period, which may not be longer than six (6) years and may not include dates before April 1, 2010. The first

list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the uses and disclosures of your medical or billing information for treatment, payment or health care operations. You also have the right to request a restriction on the medical or billing information we disclose about you to someone who is involved in your care or payment for your care, like a family member or friend. For example, you could ask that we **not** use or disclose information about your particular surgery or other particular treatment. **We are not required to agree to your request.** If we cannot agree to your requested restriction, we will notify you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. We may terminate our agreement for a restriction if we inform you and you agree.

To request restrictions, you must make your request in writing to

North Richardson Family Clinic 3200 Talon Dr., Suite 100, Richardson, Texas 75082

Right to Request Confidential Communications: You have a right to request that we communicate with you about medical treatment and options in a certain way or at a certain location. For example, you can ask that we contact you at a different phone number or address than that shown in your records.

To request confidential communications, you must make your request in writing to
North Richardson Family Clinic Talon Dr., Suite 100, Richardson, Texas 75082

We will **not** ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice. You will be offered a paper copy during the admission or registration process. You may ask us to give you a copy of this Notice at any time, or you may contact our Privacy Officer at the address above. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. This Notice may be available on a website that could be developed by this Practice or this Practice_s Billing Service. If a website is developed, you will be notified of the website address and you may obtain a copy of this Notice on that website.

Changes to This Notice

We reserve the right to change this Notice at any time. We reserve the right to make the

revised or changed Notice effective for medical and billing information we already have about you as well as any information we receive in the future. The effective date of the revised Notice will be on the first page, in the top right-hand corner. As of the effective date, distribution of the revised Notice that is in effect will be the same as above in the section describing your rights to receive a paper copy of the Notice.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the practice.

To file a complaint with the practice, contact Privacy Officer for
North Richardson Family Clinic 3200 Talon Dr., Suite 100, Richardson, Texas 75082

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, hereby acknowledge that I
(print patient name)

have received and reviewed the Privacy Notice of

North Richardson Family Clinic

(Name of Practice)

(Patient Signature and date)

RELEASE OF INFORMATION

DATE: _____

PATIENT'S NAME: _____

DATE OF BIRTH: _____

I, _____, authorize North Richardson Family Clinic to release my medical records/information that pertains to lab/radiology results and/or treatment to the following people if I am unable to be reached/contacted:

1) _____ Phone # _____

2) _____ Phone # _____

3) _____ Phone # _____

SIGNATURE: _____

I, _____, authorize North Richardson Family Clinic to leave information on my personal voicemail at the following numbers:
HOME PHONE: _____

CELL PHONE: _____

WORK PHONE: _____

COMMENTS:

_____

_____

_____

_____

SIGNATURE: _____