崔健皮膚專科診所

James J. Cui, M.D., Ph.D.

Patient Information Form 病人資料表 | Insured's Information 受保人資料

Last Name/ 姓 First Name/ 名	Last Name/ 姓 First Name/ 名
Street & Address / 住址	Street & Address / 住址
City/ 城市 State/ 州 Zip/ 郵區	City/ 城市 State/ 州 Zip/ 郵區
Home Phone/ 住址電話	Home Phone/ 住址電話
Cell Phone / 手機電話	Cell Phone/ 手機電話
D.O.B Month/月 Day/日 Year/年 Male/男 Female/女 出生日期 / / ☐ ☐	D.O.B Month/月 Day/日 Year/年 Male/男 Female/女 出生日期 / / ☐ ☐
SSN/ 工卡號碼	SSN/ 工卡號碼
Marital Status/ 婚姻狀況 ☐ married 已婚 ☐ single 未婚 ☐ other 其他	Relationship 與病人關係 ☐ spouse 配偶 ☐ Parents 父母 ☐ other 其他
Insurance Name/ 保險公司名	Insurance ID Number/ 保險號碼

Allergy/ 過敏： ☐ NKA/ 沒有 ☐ Egg/ 雞蛋 ☐ Milk/ 牛奶 ☐ Medication/ 藥物 ☐ Other/其他

Smoking/ 抽煙	Alcohol/ 酗酒	Drug Abuse/ 濫用藥物
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

(*OPTIONAL) Past Medical History/ 過去病史

	YES/是	N/否		YES/是	NO/否
Hypertension/ 高血壓	☐	☐	Mental Disease/ 精神病	☐	☐
Heart Disease/ 心臟病	☐	☐	Stroke/ 中風	☐	☐
Diabetes/ 糖尿病	☐	☐	Asthma/ 哮喘	☐	☐
Gastroenterology Disease/ 腸胃病	☐	☐	Genitourinary Disease/ 泌尿	☐	☐
Lung Disease/ 肺病	☐	☐	Skin Disease/ 皮膚疾病	☐	☐
Blood Disease/ 血液	☐	☐	Cancer Disease/ 腫瘤	☐	☐
Surgery/ 外科手術			Hospitalization/ 住院	☐	☐

Family Medical History/ 家庭病史

I hereby authorize direct payment of medical benefits to James J. Cui, M.D., for services rendered by James J. Cui., M.D. I understand that I am financially responsible for any balance if my insurance is invalid.
我同意由我受保的保險公司直接支付崔建診所提供服務的醫療費用，如果我的醫療保險無效時，我願意負責結清給崔建診所的診金和治療費用.

I authorize any holder of medical or other information about me to release to Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section.1128B of the Social Security Act and 31 U.S.C. 3801-3802 providers penalties for withholding this information.)

Patient/Guardian (Print) / (正楷/病者姓名或法定監護人)	Relationship/ 與病人關係
Patient/Guardian (Signature) / (病人簽署或法定監護人) X	Date/ 日期

PATIENT CONSENT FORM FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

***Please TURN OVER &complete Health Insurance Portability & Accountability Act Privacy Form**

請翻閱後面和簽 HIPAA 聯邦"健康保險流通與責任法案"的私隱慣例表格

PATIENT CONSENT FORM FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Dr. James J. Cui, M.D. may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare options (TPO). Please refer to Dr. James J. Cui, M.D.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Dr. James J. Cui, M.D. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. James J. Cui, M.D. Privacy Officer at 136-20 38th Avenue, Suite 5H, Flushing, NY 11354.

With my consent, Dr. James J. Cui, M.D. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dr. James J. Cui, M.D.'s uses and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing to except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dr. James J. Cui, M.D. may decline to provide treatment to me.

X_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date

_____

Print Name of Patient or Legal Guardian