先進專科診所
ADVANCED ONCOLOGY

139 Centre St., Suite 515
New York, NY10013
Teleohone: (212) 941-9020
Fax: (212) 941-9022

5816 Fort Hamilton Pkwy. # 2A
Brooklyn, NY 11219
Telephone: (718) 633-1729
Fax: (212) 941-9022

PATIENT REGISTRATION FORM

NAME: _____ CHINESE NAME: _____
LAST 姓 FIRST 名 M.I. 中文姓名

BIRTHDAY: ____ / ____ / ____ AGE: ____ SEX: ____ SOCIAL SECURITY NO.: _____
出生日期 月 MO 日 DAY 年 YEAR 年歲 性別 社會安全咭號碼

ADDRESS: _____
地址 STREET AND NUMBER APT NO.

_____
CITY STATE ZIP CODE

HOME PHONE: (____) _____ CELL PHONE: (____) _____
家居電話 家提電話

E-MAIL: _____ OCCUPATION: _____
電郵 職業

PHARMACY: _____
藥房

MARITAL: ☐ SINGLE 單身 ☐ MARRIED 已婚 ☐ OTHER 其他 _____
婚姻狀況

REFERRED BY:
介紹人

INSURANCE:
醫藥保險 _____

POLICY #: 保險號碼	GROUP NO.:	EFFECTIVE DATE: 生效日期
POLICY HOLDER: 保險人姓名	DEDUCTIBLE AMOUNT: 每年基本負責診費 $ _____	☐ PAID TO DR. _____ ☐ NOT PAID
RELATIONSHIP TO SUBSCRIBER: 與受保人之關係	☐ SELF 自己 ☐ SPOUSE 夫妻 ☐ CHILD 兒女 ☐ OTHER 其他 _____	

EMERGENCY CONTACT: 如有緊急病況，請通知親友姓名	ADDRESS: 地址
RELATIONSHIP: 與病人之關係	TEL #: ( ) 電話

I requested that payment of authorized Medicare benefits or/and private insurance benefits be made to Advanced Oncology for any services furnished me by that practice. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or other insurances any information needed to determine these benefits or the benefits or related services. I permit a copy of this authorization to be used in place of the original. I agreed to submit payment of Authorized Insurance benefits/checks to Advanced Oncology for services furnished me by the practice. I understand I am financially responsible for any balance not covered by my insurance carrier.

另附釋：我同意負責支付先進醫療中心的診症醫療服務全部診金或保險公司不支付的餘數。

Patient Signature _____ **(Date)**
病人簽名

Person Responsible for Payment:
負責支付診金人姓名

Print Name: _____ **Signature** _____ **(Date)**
簽名

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of your Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operation. we are not required to agree to this restriction, but if we do, we shall honor that agreement.

by signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on you prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and full future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent

This Consent was signed by: _____

Printed Name-Patient or Representative

_____ __/__/__

Signature Date

Relationship to Patient
(if other than patient): _____

Witness:

_____

Printed Name-Practice Representative

_____ __/__/__

Signature Date