Patient Information

Last Name 姓名:	Middle Name:	First Name 名字:	
Date of Birth 生日:	Sex 性别:	SSN 社会安全号码:	Marital Status:

Race 种族:

Asian African American/Black White Hispanic/Latino Native American Pacific Islander

Preferred Language母语:	Preferred Mode of Contact 联系方法: Text Email Call

Address 地址:	City/State 城市:	Zip Code邮政编码:

Cell Phone 手机:	Home Phone 电话:	Email 电子邮箱:

Emergency Contact #1 紧急联系人:	Relationship关系:	Phone Number手机/电话:
Emergency Contact #2 紧急联系人:	Relationship关系:	Phone Number手机/电话:

Insurance Information

Primary Insurance 第一保险:	Policy Holder 保险持有人:	Relationship 关系:
Policy Number 保险号码:	D.O.B 生日:	SSN 社会安全号码:
Employer 雇主:		Work Phone 工作电话:

Secondary Insurance 第二保险:	Policy Holder 保险持有人:	Relationship关系:
Policy Number保险号码:	D.O.B生日:	SSN 社会安全号码:
Employer雇主:		Work Phone 工作电话:

Rev. 1/1/2023

IF THIS FORM IS MODIFIED IN ANY WAY, THE ENTIRE FORM WILL BE VOID. OUR OFFICE RESERVES THE RIGHT TO DENY TREATMENT TO ANYONE, IF THIS FORM IS NOT SIGNED.
(Please ask if you would like a copy of this form.)

Patient Agreement Acknowledgement

1. Authorization of Release Information: I hereby authorize the physician to release any information required by my insurance company or another doctor or hospital, acquired in the course of my examination or treatment.
2. Authorization to Pay Benefits to Physician: In consideration of services rendered, I, the undersigned patient, do hereby irrevocably assign and transfer to my provider Dr. Henry Wang all benefits due to me whether contractual, statutory, or common law.
3. I consent to any medical treatment deemed medically necessary by the provider. I understand that prior to any treatments being rendered, the treatment will be discussed with me and all questions will be answered.
4. Patient care and confidentiality is our priority. We will not release or disclose any of your personal health information to anyone. If you would like to sign an "Authorization of Use and Disclosure of Protected Health Information" form, please ask the receptionist. This form will authorize us to release or speak to your parents, spouse, significant other, family, friend or translator regarding your personal healthcare.
5. We are contracted with most insurance companies, but please check with your insurance company to be certain that we are providers.
6. It is your responsibility as the patient and insured individual to be aware of your insurance eligibility and benefits. Wang Medical is not liable for knowing your eligibility status with your PRIMARY and/or SECONDARY insurances.
7. As the patient and policy holder of the insurance(s), it is your responsibility to notify Wang Medical about your insurance(s) and to be knowledgeable as to which insurance is your primary payer. Wang Medical is not liable for knowing which insurance is your primary and secondary. If you are unaware please contact your insurance for more information.
8. Please do not assume that your insurance will pay for services just because we obtained prior authorization. Your insurance can deny your claim for pre-existing conditions, benefits not covered by them, or other reasons deemed by them. You will be responsible for any claim denied by your insurance.
9. Almost all lab testing done in the office will be sent out and billed by the lab.
10. I understand that Dr. Henry Wang will bill my insurance as a courtesy to me. If payment is not received within 120 days from the date of billing, I will be financially responsible for any and all services rendered. Should this account have to be turned over to a collection agency, I agree to pay all collection and legal fees necessary to collect the balance on my account.
11. Please be advised and understand that this office can only code and file a claim for your visit(s) with a diagnosis that is encountered and documented in your medical record. Thus, to ask this office to change a diagnosis for the sole purpose of securing reimbursement from and insurance carrier is inappropriate and could result in a fraudulent act. For example, once we file your claim as a preventative exam, we cannot reprocess your claim as a "sick visit" for the sole purpose of securing reimbursement from your insurance company.
12. New patients may be responsible for a deposit of $100 upon your initial office visit and will be refunded to you once your claim has been successfully processed and paid by your insurance.
13. There is a $50-75 fee to complete each form that is not covered by your insurance company, such as Disability Form for DMV or FMLA forms. This fee is to be prepaid at the time of the request.
14. We will be as accurate as possible in collecting co-payments as your insurance gives us information. Any credit on your account for $25 or less will be held in your account towards future visits, unless you plan to leave our care, at which time those funds will be refunded to you in full.
15. There is a charge of $0.60 per page or $5.00 per CD for copies of medical records.
16. We accept cash, Visa or MasterCard credit and debit cards only. We do not accept check.

(Upon your request you may receive a copy of this agreement and HIPPA)

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(Please ask if you would like a copy of this form.)

Wang Medical
1346 S. Decatur Blvd
Las Vegas, NV 89102
P: (702) 889-8355

Authorization for Use and Disclosure of Protected Health Information:

I _____, hereby consent to release my medical records to following individuals only:

Name:	**Relationship:**	**Phone Number:**

_____ _____

Signature Date

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Wang Medical Acknowledgement

1. **Patient Agreement Acknowledgement: I hereby acknowledge that I have completely read and fully understand, and agree to the terms and conditions stated above and I also agree to abide by all its guidelines in order for the patient to received services from this practice.**

2. **Insurance Acknowledgement: To the best of my knowledge, I do not have any other insurance than the ones I have provided. I am not currently enrolled in a hospice program. I certify that the above facts are true to the best of my knowledge. I understand that if at anytime I change my insurance(s), I must notify Wang Medical in advance. I also understand that if I give false or inconsistent information, I will be responsible for $100 for each office visit.**

3. **Collection Policy: I hereby agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of copayment on my part, I agree to pay all collection/legal fees that may be added to my account.**

By signing below I acknowledge that I have completely reviewed and fully understand, and agree to the terms that are listed above in bullets 1, 2, and 3.

Print Name:_____

Signature:_____ **Date:_____**