REGISTRATION

(PLEASE PRINT)

HUN KANG M.D., INC.

Family Practice

2900 W. 8th Street

Los Angeles, CA 90005

Tel: (213) 382-7022

Fax: (213) 382-7088

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ (Last Name / First Name / Middle Initial) SS/HIC/Patient ID # _____

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered for _____ years ☐ Minor

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____ (Last Name / First Name / Middle Initial)

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ Signature of Patient, Parent, Guardian or Personal Representative

_____ Date

_____ Please print name of Patient, Parent, Guardian or Personal Representative

_____ Relationship to Patient

Hun Kang M.D., Inc.

Practice Name

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Hun Kang M.D., Inc. (Practice Name) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Hun Kang M.D., Inc. (Practice Name)'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. Hun Kang M.D., Inc. (Practice Name) 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 Hun kang M.D., Inc. (Practice Name) Privacy Officer at:

Hun Kang M.D., Inc.
2900 W 8th St
Los Angeles, CA 90005-1524

With my consent, Hun Kang M.D., Inc. (Practice Name) 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.

With my consent, Hun kang M.D., Inc. (Practice Name) may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Hun Kang M.D., Inc. (Practice Name) may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Hun Kang M.D., Inc. (Practice Name) restrict how it uses or discloses my PHI to carry out TPO. 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 Hun Kang M.D., Inc. 's use and disclosure of my PHI to carry out TPO.

Practice Name

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

Practice Name

Signature of Patient or Legal Guardian

Patient's Name

Date

Print Name of Patient or Legal Guardian