Patient Information (PLEASE PRINT) Date: _____

Name: _____

LAST NAME FIRST NAME MIDDLE INITIAL

Sex: M or F (circle one) Age: _____ Birthdate: ____/____/_____

SSN: _____ MARRIED SINGLE DIVORCED WIDOWED SEPARATED MINOR PARTNERED

Address: _____

STREET ADDRESS CITY STATE ZIP

Hm Phone: _____ Cell Phone: _____

Email Address: _____

In case of EMERGENCY, notify: _____

NAME AND RELATION PHONE NUMBER

PATIENT INITIALS_____ Yes, I received a copy of HIPAA privacy rights today.

PATIENT INITIALS_____ Yes, I received a copy of the Office Policies/Procedures today.

PATIENT INITIALS_____ Yes, I consent to medical treatment by a provider in this facility.

Assignment and Release

**I certify that I, and/or my dependent(s), have insurance coverage with _____ (NAME OF INSURANCE COMPANY/COMPANIES) and assign directly to Dr Robert T. Ching 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. Dr. Robert T. Ching may use my healthcare information and may disclose such information to my insurance company/companies and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

**I understand that it is MY RESPONSIBILITY to provide current information to this facility, including, but not limited to, address, telephone number(s), insurance cards/information.

**I understand that it is MY RESPONSIBILITY to verify with my insurance company whether, or not, Dr. Ching is a participating provider in my insurance carrier policy. (In-Network vs. Out-of-Network)

PATIENT OR LEGAL GUARDIAN SIGNATURE PRINTED NAME DATE SIGNED

WITNESS SIGNATURE PRINTED NAME DATE SIGNED

Patient History Form

Name: _____ **DOB:** _____

SOCIAL HISTORY: (Circle all answers that apply and fill in blanks)

Marital Status: Married Single Divorced Widow **Occupation:** _____

Living Arrangements: Number of Adults in Home: _____ Number of Minors in Home: _____ Lives Alone: Yes No

Tobacco Use: Never Smoker Smoker Former Smoker Pks/day: _____ Number of Years used: _____

Alcohol Use: Yes or No Beer Wine Liquor Often(1-2/week) Occasionally(1-2/month) Rare(1-2/year)

Caffeine Use: Yes or No Coffee Tea Energy drink Sodas Espresso Caffeine Tabs other: _____

Illicit Drug Use: Yes or No Type: Marijuana Cocaine Meth Heroine Ecstasy Opioids(street pills) PCP

Seatbelt Use: Always Sometimes Never **Smoke Detectors in Home:** Yes or No

Exercise: Yes or No walk jog exercise class yardwork dance other:_____# of Days/Week:_____

Diet: Non-Specific Vegetarian Low-Fat Diabetic Weight Loss Low Sodium Gluten-free Other: _____

Living Will: Yes or No (Legal document to make known your wishes for life prolonging medical treatments)

Medical Power of Attorney: Yes or No (Legal document appointing person to make medical decisions for you if you are unable to communicate)

FAMILY HISTORY: Adopted? Yes No	Anemia	Diabetes	Heart Prob	High BP	Cancer	High Cholest	Stroke CVA	Kidney Disease	Liver Disease	Bleeding Disorder	Thyroid Disease	Mental Health
Mother: Alive Deceased Age:												
Father: Alive Deceased Age:												
Sister(s): Alive Deceased Age(s):												
Brother(s): Alive Deceased Age(s):												
Maternal Grandmother: Alive Deceased Age:												
Maternal Grandfather: Alive Deceased Age:												
Paternal Grandmother: Alive Deceased Age:												
Paternal Grandfather: Alive Deceased Age:												

Other Family History not listed above:

MEDICAL HISTORY: (Circle all that apply) Diabetes High Blood Pressure High Cholesterol Arthritis COPD Anxiety Depression Emphysema Asthma Stomach Ulcers Migraines Stroke Heart Disease Cancer Kidney Disease Pneumonia Chronic Pain Thyroid Disease Hepatitis Cirrhosis Prostate BPH PTSD HIV Esophageal Reflux Bowel Disease Bipolar Seizures Epilepsy Schizophrenia Drug Addiction Anemia Urinary Problems Sexual Dysfunction Glaucoma Cataracts Bleeding Disorder Skin Disease Autoimmune Other:_____

Names of Other Specialist(s) involved in your care:

ALLERGIES: (Circle all that apply) NONE Penicillin Sulfa Codeine Aspirin Latex NSAIDS

Antibiotics:_____ Other:_____

SURGICAL HISTORY: PROCEDURE	MONTH/YEAR	PROCEDURE	MONTH/YEAR

HOSPITALIZATION(S): DIAGNOSIS	MONTH/YEAR	DIAGNOSIS	MONTH/ YEAR

OB/GYN HISTORY: (for women only) Age of first menses: _____ **Date of last period:**_____

Have you ever had an abnormal PAP? Yes or No **If "yes", Date & Results:**_____

Do you suffer from PMS? Yes or No **Symptoms:** _____

Pregnancies: FULL TERM_____MISCARRIAGES_____TERMINATIONS_____PREMATURE_____STILLBORN_____

Menopausal: Yes or No **Age of onset:** _____ **Symptoms:** _____

HEALTH MAINTENANCE: **Please list dates of the last exam(s) or vaccine(s) below (approximate dates are fine)**

Colonoscopy: _____PAP smear: _____ Mammogram: _____

Eye exam: _____Bone density:_____Wellness Exam: _____

Influenza vaccine: _____ Pneumonia vaccine: _____ Shingles vaccine: _____

MEDICATION HISTORY: Name of Medication / Dosage / Directions	Name of Medication / Dosage / Directions

CHING HEALTHCARE INSTITUTE

ACKNOWLEDGMENT FORM

NAME OF PATIENT (please print clearly) Date of Birth

I understand that as part of my healthcare, Ching Healthcare Institute originates and maintains health records describing my health history, symptoms, examinations, and test results, diagnoses, treatments, and any plans for future care or treatment. I understand that this information serves as:

*A basis for planning my care and treatment,

*A means of communication among the many health professionals who contribute to my care,

*A source of information for applying my diagnosis and surgical information to my bill,

*A means by which a third party payer can verify that services billed were actually provided,

*And a tool for the routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of protected health information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this acknowledgment. I understand that Ching Healthcare Institute reserves the right to change its practices and to make the new provisions, effective for all protected health information maintained by Ching Healthcare Institute.

_____ _____

Signature of Patient or Legal Representative Date Signed

_____ _____

Signature of Witness Date Signed

**Ching Healthcare Institute was unable to obtain acknowledgment/consent because:

_____Emergency _____Patient Non-Responsive _____Patient Confused/Disoriented

_____Patient Sedated _____Patient Refused-give reason:_____

CHING HEALTHCARE - PATIENT POLICIES & PROCEDURES

APPOINTMENT CONFIRMATION/NO-SHOW POLICY: In our efforts to provide timely medical care to ALL of our patients, we schedule our appointments in advance. This is done so that as many patients as possible can receive the medical attention that they need. If you have an appointment slot, and you do not show, you have occupied a slot that could have been used for a sick patient. Unfortunately, we have been forced to adopt a new policy regarding "no shows", it reads as follows: We will attempt to contact you two days prior to your appointment to verify that you will be able to attend. If we are unable to reach you, we will make a second attempt to contact you one day prior to your appointment. We will need to hear back from you, or someone representing you, that you have confirmed your appointment in order to hold that slot. You can do this by both calling and speaking to the office staff during office hours, or if it happens to be after office hours, you may certainly leave a message with the answering service. It is imperative that we have been provided the correct contact information, so that we can obtain a verbal confirmation. At 9AM on the morning of the appointments, all of the UNCONFIRMED appointments will be cancelled, and those slots will be given to sick patients that are waiting to be seen. **No patients will be assessed a no-show fee, unless they have confirmed the appointment, and then failed to attend. This policy will be strictly enforced.

**WALK-IN POLICY: We prefer that you call ahead of time for an appointment, as we try our very best to get ALL of our sick patients in on the same day, whenever possible. If you are unable to make an appointment, for any reason, you are welcome to come in on a walk-in basis, though the wait is usually longer, as you will be "worked-in" to the existing schedule.

**PHONE TREATMENT POLICY: In accordance with Texas State law and due to medical liability issues, Dr. Ching does not prescribe medications or treatments over the telephone. If a patient is ill, and needs to be seen, we will gladly make them an appointment to be evaluated by the doctor in the office. This enables Dr. Ching to examine his patients thoroughly and provide proper medical treatment.

**REFILL PROTOCOL: It is very important to be aware of how much medication you have left, and when you will be needing a refill. We have found that the quickest, and most efficient way to obtain refills for medications is for the patient to notify the pharmacy that they are in need of a refill, and request that the pharmacy ELECTRONICALLY send over a request to this office. Every request is reviewed on an individual basis, so it is imperative that you make this request AT LEAST five days BEFORE your medication runs out, to ensure that you receive them in a timely manner. Mail order requests can take a little longer, so please allow up to five business days to process those requests. As you know, there can be difficulties with insurance companies, pharmacies, and such that can cause delay in getting your meds to you, but we certainly try to expedite every request.. Any medications that are prescribed by Dr. Ching for a chronic illness/problem must be monitored by Dr. Ching with frequent office visits (usually every three to six months). Refills will not be approved for patients who do not comply with these guidelines, as these are acceptable standards of care.

**NARCOTICS: Dr. Ching DOES NOT refill any narcotic medications when the office is closed, and none of the doctors that cover for him do either. It is imperative that you take care of those refill requests during office hours, so that your medical chart can be reviewed.

**DRUG SAMPLE POLICY: It is against Texas pharmaceutical drug dispensing laws to dispense ANY medication in large quantities, or on a continual basis, without a DISPENSING LICENSE, which are only carried by pharmacies. For this reason, Ching Healthcare Institute ONLY samples pharmaceutical drugs for NEW prescriptions, as a courtesy, to be certain that the medications will be effective for the patient prior to incurring the expense of filling prescriptions.

**DOCTOR COVERAGE: When Dr. Ching is out of the office, there is ALWAYS a doctor on-call to help you. If you should need an urgent appointment, you may certainly see the Physician Assistant, or if you prefer, we can assist you in making an appointment with a covering physician in the area.

**FORMS & CORRESPONDENCE CHARGES: There is a sign in our waiting area which details the form fees. (Form fees are subject to periodic review and change) There is NO charge for prescription assistance papers/forms, or for Social Security Determination papers (per federal law). However, the patient portion of the papers should be filled out completely by the patient before being signed by the physician.

**HEALTH INSURANCE: Please consult your health insurance provider directory when seeing ANY new doctor, to ensure that insurance will cover your visits. Dr. Ching is on most policies, but there are a select few that he does not accept. Although we try to help you in any way that we can, it is the patient's responsibility to know if their physician is an in-network or an out-of-network provider. When obtaining referrals for HMO patients, it is important to be evaluated by Dr. Ching in the office, as he is the one who delegates to the specialists, when necessary.

**WORKMAN'S COMP & 3RD PARTY PAYORS: We do NOT accept or file Worker's Compensation or Third party payor's claims under ANY circumstances. If your illness or injury is to be filed (now or later) with worker's comp, or 3rd party payor, we can refer you to a clinic that will accept this type of coverage. If you insist on being seen by Dr. Ching, you must sign an affidavit stating that we are NOT treating you as a result of an accident.

PAYMENT POLICY: We will do everything that we can to assist you with your health insurance coordination of benefits and payments. In our efforts, we will file claims to the insurance companies, as long as we are provided with accurate information by the patient. As a patient, you are responsible for knowing the amount of your yearly deductible, your copayments, and your percentages owed. We ***DO NOT* bill patients for office visits, copayments, deductibles, or percentages owed. These payments **must** be met at the time that services are rendered. **WE REGRET THAT THERE ARE NO EXCEPTIONS TO THIS POLICY.** We accept payment by cash, debit/credit card, and checks (processed by Telecheck).

By signing, I acknowledge these policies and procedures, and agree to follow them. (witness signature will be obtained at office)

Patient or Guardian Signature Date Witness Date