WANG & JIANG MD PA

Prompt Care Medical Doctors
9999 Bellaire Blvd Ste 370
Houston, Tx 77036

Pearland Physicians
4320 Broadway St, Ste 100
Pearland, Tx 77581

Dairy Ashford Family Practice
1500 S. Dairy Ashford Ste 198
Houston, Tx 77077

Notice of Privacy Practices
Patient Acknowledgement

(姓名)
Patient Name: _____ **Date of Birth:** _____ (出生日期)

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practices legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosure that this practice permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health in formation and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive and accounting of disclosure of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain practices current Notice of Privacy Practices on request.

(签名)
Signature: _____ **Date:** _____ (日期)

Relationship to patient (if signed by a personal representative of patient): _____

WANG & JIANG MD PA

Prompt Care Medical Doctors
9999 Bellaire Blve Ste 370
Houston, Tx 77036

Pearland Physicans
4320 Broadway St, Ste 100
Houston, Tx 77581

Dairy Ashford Family Practice
1500 S.Dairy Ashford, Ste 198
Houston, Tx 77077

Personal Information

(姓名) (社会保险号)
Name: _____ SS#: _____

(生日) (婚姻状况 单身 已婚 丧偶 分居 离异)
DOB: _____ Marital Status: Single Married Widow Separated Divorced

(街道地址) (公寓号)
Street Address: _____ APT#: _____

(城市) (州) (邮编)
City: _____ State: _____ Zip Code: _____

(家庭电话) (手机号码) (办公电话)
Home Number: _____ Cell Phone: _____ Office: _____

(电子邮件)
E-Mail: _____

(紧急联系人)
Emergency Contact Name: _____

(紧急联系人电话) (与紧急联系人关系)
Phone Number: _____ Relationship: _____

INSURANCE

Primary Insurance Company Name: _____
ID#: _____ Group #: _____
Insured's Name _____ DOB: _____
Relationship to insured: Self _____ Spouse _____ Child _____
Secondary Insurance Company Name: _____
ID#: _____ Group #: _____

INFORMATION, ASSSIGNMENT OF BENEFIS AND FINICIAL STATMENT

- **I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.**
- **I hereby authorize Wang & Jiang MD, PA to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to Wang & Jiang MD, PA. I certify the information I have reported with regard to my insurance coverage is correct.**
- **I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either my insurance company or me at any time in writing.**
- **Verification of your insurance is not a guarantee of payment. Existing balances on your account must be paid in full prior to receiving additional services even if you are appealing or question claims payment.**
- **All lab testing is going to be done by a third party laboratory, all balances will subject to your responsibility. It is your responsibility to check your insurance laboratory coverages.**
- **If you have need to cancel or reschedule your appointment, please notify us within 24 hours. If not, you will be responsible for a $25 cancellation fee.**
- **Knowing that I am suffering from a condition requiring diagnosis and medical treatment. I do herby voluntarily consent to such diagnostic procedures and clinical care and to such medical treatment as is necessary in the judgment of the Physician(s).**
- **Agree to receive text messages for appointment reminder.**

Signature(签字): _____ **Date**(日期): _____