COMPREHENSIVE MEDICAL OFFICE,P.C

Jungman Michael Suh, MD
189-01 NORTHERN BLVD. 3RD FL FLUSHING, NY 11358
T: 718-746-0900 F:718-746-2390

PATIENT'S REGISTRATION

PATIENT'S INFORMATION

ID#_____

Name(이름):(Last)성_____(First)이름_____(MI) _____SSN#(쏘셜넘버)_____

DOB(생년월일): ____/____/_____ Gender(성별) MALE / FEMALE Single(미혼) /Married(기혼)/ Other (기타)_____

Address(주소):_____ (city)_____(state)_____(zip)_____

Phone #(전화번호): Home (_____) _____ - _____ Cell (_____) _____ - _____

Emergency Contact: Name: _____ Tel: (_____) _____ - _____

Pharmacy (약국): _____ Email Address(이메일):_____

INSURANCE INFORMATION

Primary Insurance (첫번째보험):	Secondary Insurance (두번째보험):
_____	_____
ID # (보험번호):_____	ID # (보험번호):_____
Copay: _____	Copay: _____

REFERRING INFORMATION

Referring Provider's Name(추천의사/병원이름): _____

Address: _____ (city) _____ (state) _____ (zip) _____

Phone #: (_____) _____ - _____

Primary Physician's Name (주치의): _____

Address: _____ (city) _____ (state) _____ (zip) _____

Phone #: (_____) _____ - _____

FINANCIAL AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby instruct and direct my insurance carrier to make all payments directly to: COMPREHENSIVE MEDICAL OFFICE,P.C for services rendered to me by said health care provider. This is a direct Assignment of my claim and rights for insurance benefits. I am responsible for any deductibles, if applicable. I understand that in the event my insurance carrier does not pay for any portion of the claim submitted for services provided to me, I will be personally responsible for any unpaid balance.

I hereby authorize my attorney to pay direct to the above named provider, practice, supplier or group any money owed for services rendered to me. I further authorize my attorney to render payment to the above named party, prior to the disbursement of funds to myself or other eligible parties. I understand that if this agreement is signed without the consent or acknowledgement of my attorney, it shall be deemed valid and acceptable by my attorney.

I authorize the release of any medical or other information necessary to process claims for services provided to me by the above named provider, practice, supplier or group. A photocopy of the Assignment shall be considered as effective and valid as the original.

Patient Name: _____

Signature of Patient/Guardian: _____ Date: ___ /___ / _____

PATIENT RESPONSIBILITY DISCLOSURE STATEMENT

Your signature below forms a binding agreement between Dr. Jungman M. Suh (the provider of medical services) and the Patient who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years of age). The Responsible Party is the individual who is financially responsible for payments of medical bills.

INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- **I understand that I am financially responsible for my health insurance deductible, coinsurance, termination of coverage or non-covered services.**
- **Co-payments are due at the time of service.** If your insurance requires any additional co-pays you will be responsible for payment and will be billed for it.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable" or "non-covered", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- **In the event that I do not have a secondary insurance or an insurance that does not cover 20%, I will be responsible to the remaining balance. (example: Medicaid)**
- Any amount my insurance carrier deems as patient responsibility.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

The provider of service has the right to terminate services based on noncompliance of this agreement.

I also understand that I will be responsible for any charges incurred by not providing the most current, correct insurance information to Dr. Jungman M. Suh.

Patient Name: _____

Signature of Patient/Guardian: _____ Date: ___ /___ / _____

HIPAA Notice of Privacy Practices

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.
Parts 160 and 164)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operation (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to physical or mental health or condition and related health care services.

1. Authorization:

I, _____ authorize Dr. Jungman Michael Suh to use and disclose the protected health information described below.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain billing or claims payment for your health care services.

2. Effective Period
This authorization is for release of information all past, present and future periods.

3. Extent of Authorization

A. □ I authorize the release of my complete health record (including records relating to mental healthcare, and treatment of alcohol or drug abuse).

B. □ I authorize the release of my complete health record with the exception of the following information:
□ Mental health records □ Alcohol/drug abuse treatment □ Other (please specify):_____

I authorize Dr. Jungman M Suh to release any or all information concerning my medical care to the following individual.

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Patient Name: _____

Signature of Patient/Guardian: _____ Date: ___ /___ / _____