PATIENT INFORMATION FORM 病人資料表

Patient Name (姓名) _____

病人中文姓名_____

Date of Birth (生日) _____ **Sex** □ M 男 □ F 女

Race (種族) □ Asian □ Black □ White □ Other_____

Address (地址)_____

City (城市) _____

State (州) _____ **Zip**(郵政號碼) _____

Referring By(介紹) □ Newspapers □ Web □ Others_____

Referring M.D. (介紹醫師) _____

Medical M.D. (家庭醫師) _____

□ 單身 SINGLE □ 已婚 MARRIED □ 其他 OTHER

Social Security (社安卡號) _____

Home Phone (家裡電話) _____

Cell Phone (手機號碼) _____

Text Message (短信) □ YES 是 □ NO 不是

Email* (郵箱) _____

Employed by (公司名稱) _____

Emergency Contact (緊急聯絡人) _____

Relationship (與病人關係)_____

Phone Number (電話) _____

PHARMACY NAME (藥房名字) _____

PHARMACY ADDRESS (藥房住址) _____

PHARMACY PHONE NUMBER (藥房電話) _____

PRIMARY INSURANCE 主要保險

Insurance Company (保險公司)_____

Policy #(保險卡號碼) _____

Insured (受保人) _____

Relationship to Insured (與病人關係) _____

Name (姓名)_____D.O. B(生日)_____

Were you injured on the job (因工作受傷)? □ yes 是, □ no 不是

SECONDARY INSURANCE 第二保險

Insurance Company (保險公司)_____

Policy #(保險卡號碼) _____

**** WE DO NOT ACCEPT WORKER'S COMPENSATION & NO FAULT/CAR INSURANCE**

**** WE DO NOT FILL OUT N-648 FORMS**

**** 我們不接受工傷保險和車禍保險**

**** 我們不填 N-648**

PAYMENT REQUIRED AT TIME OF SERVICE

除非已另有協議，請在服務時繳付醫療費

I HEREBY AUTHORIZE DIRECT PAYMENT OF SURGICAL/MEDICAL BENEFITS TO DR. JYH-HAUR LU FOR SERVICES RENDERED BY HIM OR UNDER HIS SUPERVISION. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE.

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT IS CORRECT. I AUTHORIZED RELEASE OF ALL RECORDS ON REQUEST. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF.

本人在此委派這醫務所的醫生和醫療專員向保險公司索取應得的醫療服務收費，並本人知道和明白若有任何醫療服務保險公司不包括或拒絕付的款項，本人需要負責繳付給這醫務所。

病人在此聲明，以上本人所提供之所有病人登記資料是正確的。我授權給此醫務所向政府福利機構索取此醫務所應得的服務費用。 此份文件的複印本與原件一樣並足以證明我的委派與認同聲明。

X / /

Signature of Patient (簽名) **Date (日期 MM/DD/YYYY)**

JYH-HAUR LU, M.D.

NEUROLOGY

PATIENT CONSENT FORM

病人同意書

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 **(HIPAA)**.

為遵守紐約州立之 1996 年健康保險流通和責任法案的規定，本醫務所公佈了此法案給與您的某些權利， 以及我們對醫療資料所做之保密和維護的守則。本醫務所之醫療資料保密通知書裏， 其中有一段說明了您身為病人在法律下所應有的權利。

在您簽署此病人同意書前，您有權閱讀本醫務所的醫療資料保密通知書。此醫療資料保密通知書的內容，也許日後因需要會有所更改， 屆時您可以與本醫務所聯絡要求索取一份紙版複印。

在醫療程序、領取醫療費和執行健康照顧方面，您有權限制本醫務所， 如何運用或透露您的醫療資料。您有權以親自簽署的書信來取消此同意書。但是，這並不影響本醫務所， 在收到您正式書面取消信之前，根據醫療程序之需要和您原先的同意的情況下，對您的健康資料所做的運用和透露。

The patient understands that 病人清楚的瞭解以下幾個重點:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
  病人的保密醫療資料將因為醫療程序需要、領取醫療費或執行健康照顧而被運用或透露
- The Practice has a Notice of Privacy Practices, and that the patient has the opportunity to review this Notice.
  本醫務所有一份醫療資料保密通知書，提供機會給病人參閱
- The Practice reserves the right to change the Notice of Privacy Practices.
  本醫務所有權更改此醫療資料保密通知書
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
  病人有權限制本醫務所如何運用或透露病人的醫療資料，但本醫務所並不需要贊同病人所提出的限制
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
  病人有權在任何期間，以書信來取消此同意書，接到取消信後，本醫務所將停止運用或透露病人的醫療資料
- The Practice may condition receipt of treatment upon the execution of this Consent.
  本醫務所可以要求病人簽此同意書後才開始為病人進行醫療的程序

This Consent was signed by: 同意書簽署人

X_____ Signature 簽署

_____ Date 日期

_____ Printed Name – Patient or Representative

_____ Relationship to Patient

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Medical Record Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
JYH-HAUR LU, MD FAAN 3916 PRINCE ST. #254, FLUSHING, NY 11354 (718)888-9870, FAX: (718)888-9025

9(a). Specific information to be released:

□ Medical Record form (insert date) _____to (insert date)_____

□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

□ Other:_____ _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**
_____ **Genetic Testing**

Authorization to Discuss Health Information

(b). □ By initialing here _____ I authorize _____
Initials Name of individual health care provider
to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm or Governmental Agency Name)

10. Reason for release of information: □ At request of individual □ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All Items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of Patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

RELEASE OF INFORMATION 醫療訊息授權

- I authorized Dr. Jyh-Haur Lu leave detailed health information on voicemail.
- I authorize the release of information including the diagnosis, records, laboratory values, prescribed medication, treatment plan, examination rendered, and claims information.

- 我允許盧志豪醫生留詳細的資料細節在電話答錄機。
- 我授权可以把我的醫療資料,包括診斷結果,所有的報告結果,藥物,以及接下來的診療計畫給我的（可多選）：

This information may be released to (please check all that apply):

☐ Spouse 配偶 Name 名字: _____

☐ Children 小孩 Name 名字: _____

☐ Other 其他人 Name 名字: _____

☐ Information is **NOT** to be released to any other family member 不允許給除了我以外的其他家人

Patient Request for Unencrypted Email Communication 要求使用電子郵件

This form authorized your provider/program to communicate with you via ***Unencrypted Email***. The email address provided is accurate and I accept responsibility for messages sent to or from this email address.

- I understand that communications over the Internet or use of an email system may not be secure and there is no assurance of confidentiality when communicating. via unencrypted email.
- I agree to hold Neuro Health PC and individuals associated with Neuro Health PC harmless from all claims and liabilities arising from or related to this request to communicate via unencrypted email.

我已授權通過未加密的電子郵件與盧志豪醫生診所聯繫，以及確保提供的電子郵件地址準確無誤。我了解使用***未加密的電子郵件系統***可能無法保證機密性並願意承擔相關責任。

Email Address 電子郵件: _____ **(please print)**