Susanna I. Chou, M.D., Ph.D.

Board-Certified Family Practice
340 Fourth Ave, suite 5A
Chula Vista, CA 91910
(619) 425-5559

We would like to welcome you to our Practice. Please complete the following information sheet. Our office policy is that payment is due at the time of services rendered. If you have insurance information, please provide this information along with your insurance identification card to the receptionist. Partial payment may be required at this time, depending on your insurance plan. Thank you

PATIENT INFORMATION:

Patient Name: _____ SSN: _____ -_____ - _____

Date of Birth: _____ / _____/_____ Sex: _____ Age: _____ Marital Status _____

Home Address: _____ City, State, Zip Code: _____

Allergies of Patient: _____ Home Phone: (____) _____-_____ Work Phone: (__) ____ - _____

Primary Language: ☐ Eng ☐ Span ☐ Other: _____ Referred By: ☐ Friend ☐ Relative ☐ Other _____

Email Address: _____

FINANCIAL RESPONSIBILITY:

Place a √ on your current medical coverage.

☐ Healthy Families ☐ Medi-Cal ☐ Medi-Care ☐ Private Insurance (PPO, HMO) ☐ Cash Pay

Name of Insurance Carrier: _____

CONTACT IN CASE OF EMERGENCY:

Person to notify in case of emergency (Who does not live with you):

_____

Relationship to patient: _____

Address: _____

Phone: (_____)_____-_____ Alternate Phone: (_____)_____-_____

SUSANNA I. CHOU, MD, PhD

INSURANCE SUBSCRIBER INFORMATION:

I Request payment of Medicare and/or other insurance benefits be remitted directly to Susanna Chou MD, PhD for services rendered me. I authorize the practice to release any medical information about me to the Health Care Financing Administration or its agents and/or any private insurance organization any information about me needed to determine these benefits or benefits payable for related services.

I acknowledge that if my insurance does not cover my visit, I am fully responsible for services rendered.

HIPAA PRIVACY ACT INFORMATION:

I acknowledge that I received a copy of the HIPAA Privacy Act Information handout.

CANCELLATION POLICY

I acknowledge that I received a copy of the Cancellation Policy.

FOR MEDI-CAL PATIENTS ONLY:
California Welfare and Institutions Code 14043.341
The provider who obtains a biological specimen from a Medi-Cal beneficiary for the performance of a clinical laboratory test or examination shall maintain a record of the signature of the person receiving the drug or device or from whom a biological specimen was obtained. I have read and understand the information provided to me and agree to these procedures.

RELEASE/REQUEST OF INFORMATION

To the extent necessary to determine liability for payment and to obtain reimbursement, the office of Dr. Susanna Chou, MD, PhD. may disclose/request portions of the patient's financial and medical records to any person, corporation or to any agent of any such person or corporation which is our may be liable for all or any portion of the office of Dr. Susanna Chou, MD, PhD. charges, including but not limited to insurance companies, employers health service plans or Worker's Compensation carriers. The office of Dr. Susanna I. Chou may also make available pertinent information to government social agencies and other health care providers as necessary to insure continuity of care and availability of health care service for the patient and the patient's family.

Advanced Directives: *I have received information about advanced directives and understand that I have the right to formulate advanced directives regarding my care and have them placed in my medical record. I understand I have the right to change my instructions at a later date. I would like to receive additional information.* **(Y/N)____.**

I acknowledge the above with the following exclusions: ☐ None ☐ List: _____

_____ _____
Patient Signature or legal Representative. Date

_____ _____
Print Name Relationship

PLACE CARD HERE