HONGSHIK HAN, M.D., INC.
7005 N. Maple Ave., Suite 108
Fresno, CA 93720
(Located at the NW corner of Maple & Herndon Ave.)
Ph: (559) 325-3832 / Fax: (559) 325-2603

A Member of Sante' Foundation Medical Group & Part of Sante' Health Foundation

Dear Patient:

Welcome to Dr. Hongshik Han's office, and thank you for selecting our practice to care for your medical needs. Dr. Han is a Board Certified plastic surgeon specializing in hand surgery. He also has extensive experience in aesthetic, reconstructive, and micro surgery.

Please make note of the following:

1) You will need to complete all the enclosed forms in **black ink** and bring them with you to your appointment on ______________________________________ at _________________________.

2) **If your insurance company requires a referral or prior authorization for specialty care, it is your responsibility to be certain we have that referral prior to your appointment.** Your primary care physician will have to obtain the referral for Dr. Han.

3) **Bring your insurance card(s) and the name and address of your primary care doctor.** If you have a co-payment, please be prepared to pay that amount at the time of your visit**.** We accept checks, cash, or credit card. Patients will be charged a $35.00 fee for failure to notify our office 24 hours in advance if you cannot keep your appointment.

4) If you have had any x-rays, CT's, MRI's, or nerve conduction studies, please **hand carry your imaging CD** with you to your appointment in our office.

5) If you require Disability forms to be filled out, there will be a $30 fee for the preparation of these forms. The fee for FMLA forms is $20 and the fee for extension forms is $10.

Thank you for your attention to these matters. If you have any questions, please call our office at the above number. For more information about our office and the procedures Dr. Han performs, you may visit our website at **www.drhansurgery.com**.

Our office phone hours are Monday-Thursday 9:00 a.m.–5:00 pm (closed from noon to 2:00 pm), and Friday 9:00 am-12:00 Noon (except holidays).

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Please print and complete all sections on all pages.

PATIENT'S PERSONAL INFORMATION

Patient's Name: ____
First Middle Last

Patient's Address: ____
Street City/State Zip Code

Home Phone: ______________________ Work Phone: _____________________ Cell Phone: ______________________

Patient's SS#: ______________________________ Patient's Birthday: ___________________________ Age: __________

Patient's Sex: ☐Male ☐Female Patient's Occupation ____

Patient's Employer: ____Employer's Phone: ______________________

Emergency Contact Person: _____________________________________ Relation to Patient: __________________________

Emergency Contact's Phone #: ______________________________ Emergency Contact's DOB_________________________

Is the injury work-related? Yes _____ No _____

Date of Injury (if known): ____

Please specify area to be examined: ____

PATIENT'S INSURANCE INFORMATION

Primary Insurance Carrier: _________________________ Group #: __________________ ID#: _____________________

Policyholder's Name: ___________________________________ Policy Holder's SS#: ______________________________

Policyholder's Date of Birth: ____________________________

Secondary Insurance: _____________________________ Group #: __________________ ID#:______________________

Policyholder's Name: ___________________________________ Policy Holder's SS#: ______________________________

Policyholder's Date of Birth: ___________________________

Worker's Comp Insurance Name: ________________________________ Claim #: _______________________________

Worker's Comp Adjuster's Name: __________________________________ W/C Adjuster's Phone #: ______________________

PATIENT'S REFERRAL INFORMATION

Name of Primary Care Physician: ____

Primary Care Physician's Phone #: ____

Primary Care Physician's Address: ____
Street City/State Zip Code

Name of Referring Physician: _________________________________ Date: ________________ Phone #: _______________

Name: ____

Social History

Marital Status	☐ Single	☐ Married	☐ Divorced	☐ Widowed	
Exercise	☐ Daily	☐ Weekly	☐ Monthly	☐ Never	
Smoking	☐ Yes (how much?) _______________		☐ Quit (how long ago?) ________		☐ Never
Alcohol	☐ Yes (how much?) _______________		☐ Occasionally		☐ Never

Family History

Member	Alive	Deceased	Age/s
Father	☐	☐	_________
Mother	☐	☐	_________
Sister/s #________	#______	#______	_________
Brother/s #________	#______	#______	_________
Child(ren) #_________	#______	#______	_________

Review of Systems

Are you currently having problems with any of the following:

	Yes	No	Describe all yes responses.
Eyes	☐	☐	________________________________
Ears, Nose, Throat	☐	☐	________________________________
Heart	☐	☐	________________________________
Lungs, Breathing	☐	☐	________________________________
Bladder	☐	☐	________________________________
Bleeding	☐	☐	________________________________
Balance Problems	☐	☐	________________________________
Blackout / Fainting	☐	☐	________________________________
Numbness / Tingling	☐	☐	________________________________
Psychological Problems	☐	☐	________________________________
Weight Loss	☐	☐	________________________________
Fevers	☐	☐	________________________________
Osteoporosis	☐	☐	________________________________
Other	☐	☐	________________________________

Height: __________ Weight: __________ Race: ___________________ Primary Language: _________________

Dominant Hand (please circle): Right Left

Preferred Pharmacy (Name and Phone #): ____

Patient Signature: ____ Date: _______________________

Patient's Name: ______________________________________ **Today's Date:** ______________________

Allergies to Medications: ____

Please mark if you have had the following:

- ☐ High Blood Pressure
- ☐ Heart Arrhythmia
- ☐ Coronary Artery Disease or Heart Attacks
- ☐ Seizures / Epilepsy
- ☐ Problems with Anesthesia
- ☐ Asthma
- ☐ Diabetes
- ☐ Liver Disorder
- ☐ Rheumatoid Arthritis
- ☐ Deep Vein Thrombosis
- ☐ Bleeding Disorder
- ☐ Emphysema or COPD
- ☐ Ulcers
- ☐ TB
- ☐ Arthritis
- ☐ Polio
- ☐ Cancer (type): ____
- ☐ Other: ____

Surgeries / Hospitalizations

Year	Location	Procedure

Medications Please list ALL medications that you are currently taking.

Drug	Dose	Prescribing Doctor	Reason for medication

HONGSHIK HAN, M.D., INC.
PATIENT AGREEMENT

Cancellations / No Show / Late Appointments Policy:
We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit due to a seemingly "full" appointment schedule.

If an office appointment is not cancelled at least 24 hours in advance or if you do not show up for your appointment, you will be charged a thirty-five ($35) fee; this will not be covered by your insurance company. After 3 missed appointments, Hongshik Han, MD reserves the right to no longer schedule you into our system. The staff and providers will do their best to accommodate patients who are running late, but patients may be asked to reschedule if they have not arrived at their appointment on time. _____ (initial)

Patients who do not show up for surgery without a call to cancel at least 24 hours in advance are considered a No Show and will be subject to a $100 No Show Fee. This fee will not be submitted to insurance. It is your responsibility and must be paid in full prior to rescheduling your surgery.

Right to Discontinue Treatment:
Hongshik Han, MD has the right to discontinue care for any appropriate reason, such as excessive missed appointments, disruptive personal behavior, refusal to seek specialty referrals or obtain laboratory tests as ordered, lack of compliance to prescribed therapies, treatment, or medication regimens, and ignoring established policies relating to payment and practice operations. In such cases, the patient or patient's representative agrees to accept full responsibility for pursuing alternate professional care. A letter will be sent out informing the patient of discontinuation of treatment and the office will continue to see the patient for 30 days from the date of discontinuation notice. _____ (initial)

Medications/Controlled Substances:
Medication will be prescribed with care and only for good reason. When a patient is asked to take medicine, please follow the directions carefully and take as prescribed by the provider. NO medication will be prescribed without an in-person evaluation in the office. Patient agrees to tell the doctor of all other medications that have been prescribed and agrees to only go to one pharmacy for controlled substances. Patient also agrees to inform any other health care providers of all controlled substances that have been prescribed and agrees not to seek additional prescriptions from other providers without informing Dr. Han. _____ (initial)

HONGSHIK HAN, M.D., INC.

Medical Records Privacy

It is the policy of Hongshik Han, M.D., Inc. to maintain the privacy of the Medical Records we use. Our records consist of our evaluations and recommendations as well as copies of laboratory studies, x-ray, and other studies, and consultations from other physicians. Some of the records are actually from the hospital and are included in the file. The Medical Record also includes letters to your referring physician and other consultants involved in your care. Finally, the record contains certain demographic information and your insurance information.

At Dr. Han's office, we are always concerned about the privacy of these records. It is our policy not to release any information from these records to others without your written permission. The only exceptions to this rule are records we send to your referring physician and consultants and the occasional request by your insurance company. If you are not aware, most insurance companies have you sign a Medical Information Release Form when you sign up with them.

We do not release information from the record unless you request and sign a release form. You have the right to specify which portion of the record we may release. Other than the exceptions mentioned above, Dr. Han will maintain a separate record of the date any information was sent and to whom it was sent. A nominal fee may be charged for the copying of the medical record.

If you have any questions about the Medical Record, feel free to ask our staff or Dr. Han.

Hongshik Han, M.D., Inc.

Signature: ____________________________________ **Date:** ______________________
(Patient or Guardian)

ASSIGNMENT OF INSURANCE BENEFITS & FINANCIAL POLICIES

(NOT APPLICABLE TO WORKERS COMP PATIENTS)

As a courtesy to our patients, we will bill your primary insurance carrier and secondary insurance, if applicable.

Hongshik Han, M.D., Inc. is a member of Sante' Foundation Medical Group (SFMG) and you may receive a bill from SFMG for your services with our group.

I, as the patient / responsible party, hereby authorize payment for services rendered to be made directly to Sante' Foundation Medical Group.

I understand that the balance on my account is DUE IN FULL within 65 days of my appointment date and if my insurance carrier has not remitted payment within this time frame, I will pay the balance due. This also applies to any charges not covered or paid by my insurance carrier.

Signature of Guarantor ____ Date __________________

Relationship to Patient ____

Responsibility for Payment: I understand that I am ultimately accountable and responsible to make payment for all services rendered to me. I will accept responsibility to pay the balance, if any, left over after my insurance(s) has made payment on services rendered to me. I will pay for any known or expected charges at the time of the office visit unless other arrangements have been made. I agree to accept full responsibility for charges incurred for services on days that I cannot produce proof of insurance that certifies my eligibility with the plan. _____ (patient initials)

I understand that continual non-payment is reason for termination from the practice. ______ (patient initials)

FOR COSMETIC OR NO MEDICAL INSURANCE

If I do not have medical insurance or if I am being treated for cosmetic procedures, all surgical services will be prepaid and all office visits will be paid at the time services are rendered.

Signature of Guarantor ____ Date ___________________

Relationship to Patient ____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, ____, as the patient / responsible party, hereby authorize Hongshik Han, M.D. to release medical records, photos, or information pertaining to my treatment, which may be needed in the process of obtaining insurance pre-authorizations or may be needed for the purpose of billing my insurance carriers for several services rendered.

I also authorize release of any records to other physicians as needed to assist with medical needs.

Signature of Guarantor ____ Date _________________

Relationship to Patient ____

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