

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).

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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister/s # _____	# _____	# _____	_____
Brother/s # _____	# _____	# _____	_____
Child(ren) # _____	# _____	# _____	_____

Review of Systems

Are you currently having problems with any of the following:

	<u>Yes</u>	<u>No</u>	Describe all yes responses.
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs, Breathing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	_____
Balance Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blackout / Fainting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Numbness / Tingling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychological Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Height: _____ Weight: _____ Race: _____ Primary Language: _____

Dominant Hand (please circle): Right Left

Preferred Pharmacy (Name and Phone #): _____

Patient Signature: _____ Date: _____

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 _____

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.