NATOMAS FAMILY PRACTICE INC.
convenience, compassion, community

Steve D. Hwang, D.O. Patrick C.Lau, M.D.

2410 Del Paso Rd. Sacramento, Ca 95834
Office: (916) 928-0856 Fax: (916) 928-1584

PATIENT DEMOGRAPHICS

DATE: _____ ☐MALE ☐FEMALE

PATIENT FULL NAME: _____

Date of Birth: _____ Social Security #: ___-___-____

EMAIL: _____

Circle One: Single Married Separated Divorce Widowed

PATIENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Patient Phone ( ) ___-____ Message Phone ( ) ___-____

***** IF PATIENT IS UNDER 18 YEARS OF AGE*****

Guarantor/Responsible Party Name: _____

Guarantor/Responsible Party Name SSN: _____

Relationship to Patient: _____ Date of Birth: _____

_____

Street City State Zip

Name of Primary Insurance: _____

Subscriber's Name: _____ Date of Birth: _____ SSN: ___-___-____

Patient Relation to Subscriber: SELF SPOUSE CHILD OTHER: _____

Ins. ID/ Policy #: _____ Group #: _____ Effective Date: _____

Name of Secondary Insurance: _____

Subscriber's Name: _____ Date of Birth: _____ SSN: ___-___-____

Patient Relation to Subscriber: SELF SPOUSE CHILD OTHER: _____

Ins. ID/ Policy #: _____ Group #: _____ Effective Date: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone ( ) ___-____

Emergency Contact Address: _____

Natomas Family Practice

Patick Lau, MD. Steve Hwang, DO

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Financially Responsible

I authorize the release of any medical information necessary to proces the claim and request that payment of any benefits be made to the undersigned physician or supplier for services described below. I undestand I am financially responsible for authorization, should the account be referred to an Attorney for fees and collection expenses. I certify that everything filled out above is to the best of my knowledge.

It is your responsibility to notify us of any changes to your insurance, home or mailing address, and phone number(s).

Please return this signed form to the receptionist. Thank you for your cooperation.

Signature:_____ **Date:**_____

(INSURED OR AUTHORIZED PERSON)

MEDICAL INFORMATION RELEASE FORM

(HIPAA RELEASE FORM)

NAME_____, DATE OF BIRTH_____

RELEASE OF INFORMATION

{} SPOUSE NAME_____

{} CHILD NAME_____

{} OTHER NAME_____

{} INFORMATION IS NOT TO BE RELEASED TO ANYONE

THIS RELEASE OF INFORMATION WILL REMAIN IN EFFECT FOR ONE YEAR OR UNTIL TERMINATED BY ME IN WRITING.

MESSAGES

PLEASE CALL {} MY HOME {} MY WORK {} MY CELL PHONE_____

IF UNABLE TO REACH ME:

{} YOU MAY LEAVE A DETAILED MESSAGE

{} PLEASE LEAVE MESSAGE ASKING ME TO RETURN YOUR CALL

OTHER_____

BEST TIME TO REACH ME IS (DAY) _____BETWEEN (TIME)_____

SIGNED:_____ DATE:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Natomas Family Practice's Notice of Privacy Practices for protected health information.

Date: _____ Name of Patient: _____
Print Name

DOB: _____ _____
Signature of Patient/Personal Representative

Documentation of Good Faith Effort to Obtain Written Acknowledgement

I made a good faith effort to obtain the patient's written acknowledgement of our Notice of Privacy Practices for protected health information by (check all that apply):

- ☐ Showing the patient the Notice of Privacy Practices posted in our office.
- ☐ Giving the patient a copy of our Notice of Privacy Practices to read prior to receiving any treatment or service.
- ☐ Giving the patient all necessary information to obtain our Notice of Privacy Practices on our website.
- ☐ Asking the patient to sign this Acknowledgement form.
- ☐ Other (explain in detail)_____

_____

_____

I was unable to obtain the patient's written Acknowledgement because (check all that apply):

- ☐ The patient refused to sign this form.
- ☐ The patient would not sign the form because the patient said he/she did not understand the Notice.
- ☐ Other (explain in detail)_____

_____

_____

Date: _____ Name: _____

Notes: This written Acknowledgement must be completed no later than the first date health care services or treatment are provided to the patient after December 12, 2016. This Acknowledgement must be retained in the patient's permanent records