Floyd Shon, MD
33 Creek Road, Ste.130
Irvine, CA 92604
(949) 855-2772

PATIENT REGISTRATION

PATIENT INFORMATION

Name: Last MI	First		DOB:	Sex: M F
Address: Street	City, State		Zip	
E-mail:	Cell Phone:		Home Phone:	
Emergency Contact Name: Relationship: Cell Phone: Home Phone:			How were you referred to our office?	

INSURANCE INFORMATION

Primary Insurance Carrier: ID #:	Insured: Relationship: DOB:
Secondary Insurance Carrier: ID#:	Insured: Relationship: DOB:
Work Comp Carrier:	Claim #: DOI: Adjuster: Phone: Fax:
Check here if you are a Cash patient __	Please provide a copy (front and back) of your insurance card and ID upon check-in

Assignment of benefits and authorization to release information:
I hereby irrevocably assign the insurance benefit payment, both basic and major medical, to which I am entitled directly to the doctor rendering service. I understand that I am financially responsible for the charges not covered by the assignment. A photocopy of this authorization is accepted with the same authority as the original. I hereby authorize the doctor rendering service to release any information required in the course of my examination or treatment.

Patient Signature____ Date________________________
Parent/Legal Guardian if patient is a minor

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HEALTH HISTORY

NAME: D.O.B. DATE:

HEIGHT: WEIGHT:
DOMINANT HAND: R / L

PRIMARY CARE PHYSICIAN NAME:
CITY: LAST VISIT:

PHARMACY:

ADDRESS: PHONE:

REASON FOR VISIT: DATE OF INJURY/ONSET:

HOW DID THE INJURY OCCUR?

HAVE YOU HAD PREVIOUS TREATMENT/TESTING FOR THIS INJURY (XRAY, MRI, MEDICATIONS, ETC) Y / N
PLEASE LIST:

IF YES, FROM WHERE & WHEN?

PAIN LEVEL 0 1 2 3 4 5 6 7 8 9 10

PREVIOUS INJURIES TO THIS AREA IN THE PAST?

MEDICAL HISTORY (DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING): PROBLEMS:

- ❑ BLEEDING TENDENCIES
- ❑ BRAIN, NERVE, MUSCLE DISEASE
- ❑ CANCER
- ❑ DIABETES
- ❑ HEART DISEASE
- ❑ LIVER DISEASE
- ❑ LUNG DISEASE
- ❑ INFECTIOUS DISEASE
- ❑ THYROID DISEASE
- ❑ HYPERTENSION
- ❑ HIGH CHOLESTEROL
- ❑ SLEEP APNEA
- ❑ OTHER________________
  ____
- ❑ NONE

PLEASE EXPLAIN:

SYSTEMS REVIEW: LIST

- ❑ CARDIO/RESP Y / N
- ❑ ENDOCRINE Y / N
- ❑ GU/ GI Y / N
- ❑ NEURO Y / N
- ❑ VASCULAR Y / N

LIST:________________________
____
____

PAST SURGICAL HISTORY:

LIST ALL MEDICATIONS AND DOSAGE:

ALLERGIES AND REACTIONS:

DO YOU SMOKE? Y / N IF YES, HOW MUCH PER DAY? QUIT DATE:

DO YOU DRINK ALCOHOL? Y / N IF YES,HOW MANY DRINKS A WEEK?

IF APPLICABLE, CARDIOLOGIST NAME: CITY: LAST VISIT:

HAVE YOU TESTED POSITIVE FOR COVID-19 IN THE LAST 3 MONTHS?

❑ REVIEWED BY FLOYD SHON, MD
DATE:_______

NOTICE OF GENERAL DISCLAIMERS

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AUTHORIZATION FOR MEDICAL CARE & RELEASE OF INFORMATION

I hereby authorize Floyd Shon, MD, Inc to render necessary medical services to me for the purposes of treating my medical condition. I understand that in providing care to me, the Physician(s) and staff, may require additional medical information. Therefore, I hereby give authorization for Floyd Shon, MD,Inc to obtain any of my medical information from previous, present and future treating Physicians, and/or other medical providers and facilities for the duration of my treatment. I also authorize Floyd Shon, MD,Inc, and their billing facility, to furnish information to any insurance carrier that I am filing a claim with for the purpose of payment concerning my treatment, as well as any entity requiring information for the purposes of further treatment regarding my illness/condition. A copy of this authorization shall serve as valid as the original.

DURABLE MEDICAL EQUIPMENT (DME) / SUPPLIES / OTHER MISCELLANEOUS SERVICES WAIVER

Certain medical conditions may require the use of DME, supplies and other miscellaneous services, which include any of the following: pre-fabricated and custom-fabricated casts, splints/braces, dressings, slings, cushions, injections, etc. Although these are considered to be “medically necessary” by my Physician, many insurance carriers may deny payment of such items. If I am covered by private insurance, I understand that Floyd Shon, MD,Inc will bill my insurance carrier for these items in good faith; however, if it is known beforehand, Floyd Shon, MD,Inc will require pre-payment for non-covered items (note: many insurance carriers consider pre-fabricated splints to be non-covered items). In the event that billed items are denied by my carrier, I will be held responsible for paying these non-covered items. For pre-determined, non-covered items, payment is due when the item is dispensed

PAYMENT AGREEMENT POLICY

I understand that it is my responsibility to know if Floyd Shon, MD,Inc is an approved medical provider for my insurance plan. In the event that the Physician is not an approved medical provider, I acknowledge that I will be responsible for paying for any services and/or items not covered by my insurance plan. I understand that co-pays, deductibles, and other pre-determined costs are due at the time of my treatment. All unpaid claims, outstanding balances, and any other insurance payment denial is my responsibility to pay. I hereby agree to pay for all accrued charges until my account is satisfied in full. I am responsible for responding to any correspondence sent to me by Floyd Shon, MD,Inc and/or its billing service, and therefore, I understand that it is my responsibility to inform Floyd Shon, MD,Inc of my correct mailing address so that all correspondence can be mailed to me as well as updated insurance information. If I am a Cash-paying patient, I understand that “payment in full” is due at the time services are rendered. If I pay with a check, I understand that there is a $30.00 Non-sufficient funds (NSF) fee that will be added to all returned checks. A copy of this authorization shall serve as valid as the original.

OFFICE POLICIES

Minors are required to be accompanied by a parent or other legal guardian on each visit.

Our office requires advance notification for any appointment that needs to be cancelled. Notice of 24-hours is required, in order to allow us time to fill the appointment slot. If you fail to give us adequate notice, or if you “no show” for your appointment, you will be charged a fee as follows: $25 for a missed appointment. However, the first missed appointment fee will be waived if you reschedule your appointment, and show up. Any missed appointments thereafter will be charged at $25 and will not be waived.

NOTICE OF PRIVACY PRACTICES RECEIPT: HIPAA POLICIES AND PROCEDURES

NAME OF PRACTICE: Floyd Shon, MD, 33 Creek Rd, Ste 130, Irvine, CA 92604

PRIVACY OFFICIAL: Floyd Shon, MD (949) 855-2772
NOTICE TO CONSUMERS:(To file a complaint contact): The US Department of Health & Human Services Office of Civil Rights, 200 Independence Ave, S.W.,Washington, DC, 20201 Ph: 202 619-0257 Toll Free: 877-696-6775

I acknowledge that I was provided the ability to review and receive a copy of the Notice of Privacy Practices of the medical practice(s) named above.

NOTICE OF MEDICAL DISPUTE RESOLUTION

I understand that Floyd Shon, MD,Inc reserves the right to institute “Third-party Mediation” as a standard resolution method for medical disputes should they arise. I understand that “Mediation” is defined as an “alternative dispute resolution” method in which disputing parties (at their own expense) “work with a neutral third party called a ‘mediator,’ who facilitates the resolution of the parties’ disputes by supervising the exchange of information and the bargaining process,” including but not limited to “…helping the parties find common ground and deal with unrealistic expectations” (source:http://adr.findlaw.com/mediation/what-is-mediation-.html). If medical disputes arise, I agree to “Third-party Mediation” resolution unless collectively it is decided that mediation is not appropriate for any reason and/or it is decided that disputes are best resolved in a traditional court setting. I understand that (at any time) I have the right to further discuss the Medical Dispute Resolution process with my Physician and/or any designated representative of Floyd Shon, MD,Inc. I also understand that my disagreement to any part of the Medical Dispute Resolution process described within (at any time) can serve as reasonable grounds to be terminated from care. A copy of this signed authorization shall serve as valid as the original.

PATIENT NAME (PRINTED): ____

PATIENT/LEGAL GUARDIAN SIGNATURE: _____________________________________ DATE: __________________

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RELEASE OF INFORMATION AUTHORIZATION FORM

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), our office requires written identification of all entities the patient/legal guardian will give unlimited, permitted access to their Protected Health Information (PHI). PHI can include, but is not limited to, medical reports, laboratory reports, appointment information and financial/billing records. For further, detailed information regarding our Center's HIPAA practices, please refer to our HIPAA policy posted online at www.floydshonmd.com and/or our reference manual located at our Receptionary Desk. Please ask the front desk if you would like a copy of our privacy practices.

NOTICE TO PATIENT/LEGAL GUARDIAN: Authorization to release PHI (to the patient, their legal guardian, their legal survivor, referring Physician, insurance carrier(s) and/or any other entity the patient/legal guardian designates as financially responsible for their services) is deemed to be "automatic" in nature and is a condition of being able to receive services by our Facility's healthcare providers. The patient/legal guardian reserves the right to submit to our office (in writing) a request to prohibit the release of information to any entity listed above and/or below; however, our office also reserves the right to deny service if it concludes that prohibiting such information will interfere in our ability to render services. Floyd Shon, MD, Inc is not responsible for any subsequent distribution of the patient's PHI once it has been distributed to any of the above-listed and/or below-listed entities and/or their elected representatives.

E-MAIL DISCLAIMER: Please note that if the patient/legal guardian provides our office with an e-mail address, the patient/legal guardian is providing Floyd Shon, MD, Inc. with automatic authorization to communicate medical (and account) information to the patient/legal guardian and/or any of their elected representatives, via that e-mail address. Additionally, this authorization allows our Center to e-mail medical information to any healthcare provider directly involved in the care of the patient (and who elects to communicate via e-mail). If the patient/legal guardian elects not to have any information communicated via e-mail, the patient/legal guardian is hereby instructed to not provide our Center with an e-mail address and to provide our Center with written notification prohibiting the sharing of the patient's information electronically with any entity.

RIGHT TO REVOKE/CHANGE AUTHORIZATION: The patient/legal guardian may revoke or change any or all parts of their designations below at any time by completing a new Release of Information form and submitting it to the Floyd Shon, MD. The patient/legal guardian acknowledges that any revocations or other changes made to this authorization are effective the date each new form is completed and signed. Revocations and other changes are not retroactive.

PATIENT ACKNOWLEDGEMENT: The following list will serve as formal acknowledgement and authorization, on my (patient/legal guardian) behalf, to release and/or discuss any/all information related to my medical condition and treatment with:

❑ Me (the patient/legal guardian only)
❑ Me (the patient/legal guardian) **AND (**check box and list First, Last Name and phone number):

❑ Spouse/Domestic Partner Name:__________________________phone#:________________

❑ Child(ren): Name:__________________________phone#:________________

Name:__________________________phone#:________________

❑ Other: Name:__________________________phone#_________________

PATIENT NAME (PRINTED): ____

PATIENT/LEGAL GUARDIAN SIGNATURE: _____________________________________ **DATE:** _________________

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MEDICARE (AND MEDI-GAP) ACKNOWLEDGMENT FORM

This notice contains important notices for Medicare patients. Despite your signed designation, some services may not be covered by Medicare or Medi-Gap benefits.

ADVANCE BENEFICIARY NOTICE (ABN) / NOTICE OF EXCLUSIONS

Floyd Shon, MD, is a contracted Medicare provider. Medicare may not pay for the following services and products provided by our Office:

- In-office procedures or other “same-day” services
- Surgical procedures – including the services of surgical assistants
- Durable Medical Equipment (DME) – including prefabricated and custom-made splints, slings, casts and other similar items
    - Dressings/bandages (and all related supplies)
- “Other services” provided by non-affiliated entities (i.e. MRIs, CT scans, nerve studies, lab studies and other similar services)
    - Medications prescribed by our Physicians
- Any items provided to any patient who is a resident of a skilled nursing facility, or a part of a skilled nursing facility

For a complete, updated summary of non-covered items, please contact the Centers for Medicare and Medicaid Services at 1-800-MEDICARE (1-800-633-4227) or visit www.cms.hhs.gov .

MEDICARE SIGNATURE ON-FILE

With my signature below, I request the Centers for Medicare and Medicaid Services to make payment, for services provided to me, to Floyd Shon, MD, Inc also request Medi-Gap (supplemental) insurance benefits to be made payable to Floyd Shon, MD. I authorize my signature below to be used for both paper and electronic claim submissions.

I authorize any holder of my medical information to release this information to Medicare, my Medi-Gap carrier and their agents for the purpose of paying Floyd Shon, MD, or services provided to me. I accept that services, products and account balances that are not paid by Medicare or Medi-Gap benefits will be billed directly to me, in accordance to this notice.

PATIENT NAME (print):____

PATIENT SIGNATURE: ____ DATE: ________________