Uyen Jackie Nguyen, MD INC Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Missed Appointments -- Our policy is to charge for missed appointments not canceled within 24 hours of time. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.

Our charges are as follows:

Office Visit	$35.00
2 No Shows	$35.00

Repeated no shows may result in the patient being discharged from our office.

Form Completion -- There may be an initial charge of $35 for each form a patient may request us to complete us as: DMV forms, Assisted Living forms, health assessments, letter(s) to third parties, etc. A $15.00 fee may apply for disability extensions. If forms or reports are lengthy, charges may be higher depending on the amount of time spent on completion. **This charge is not covered by your insurance.**

Patient Portal -- The patient portal is our preferred way to communicate to our patients. We utilize the portal for exchanging secure messages, medication renewals, appointments referrals and test results.

Co-payments and Deductibles -- All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying at each visit.

Coverage Changes -- If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not play your claim in 45 days, the balance will automatically be billed to you.

Prescriptions -- All prescription refills should be requested prior to 4:30pm, Monday - Friday. We do not approve refills prescriptions during off hours.

Thank you for understanding our policy. Please let us know if you have any questions or concerns.

I have read and understand the policy and agree to abide by its guidelines.

Signature **Printed Name/Relationship** **Date**

04/2024

UYEN JACKIE NGUYEN, MD. INC.

WELCOME TO OUR PRACTICE

Name: _____ Date: _____
Last First M.I

Birth date: _____ Social Security#:_____

Mailing Address: _____

Home #:_____ Work #:_____ Cell #:_____

Occupation: _____ Employer: _____

Employer Address: _____

Emergency Contact: _____
Name Home/Cell/Work # Relationship

Pharmacy Name: _____ Cross Streets/City: _____

Whom may we thank for referring you: _____

Past Illnesses: _____

_____

Past Surgeries (include Dates):_____

_____

_____

Past Hospitalizations (include dates):_____

_____

Past Immunizations (include dates):_____

_____

Current Medications: _____

_____

_____

Medication Allergies (include reactions):_____

_____

Women Only: Last Pap Smear: _____ Last Menstrual Period: _____ Last Mammogram: _____

Habits: Tobacco: Packs daily: _____ How long: _____ Date quit: _____
Alcohol (type/amount):_____ Coffee/Tea: Cups Daily_____
Substance Abuse: _____ Exercise Routine: _____

Medical History Of: (Please list any Cancer, Heart Disease, Diabetes, Lung Disease, or Surgeries):
Father: _____
Mother: _____
Brothers: _____
Sisters: _____
Daughters: _____ Sons: _____

Mark illnesses which have occurred in any of your blood relatives: ☐Diabetes ☐Heart Diseases ☐Cancer ☐High Blood Pressure ☐Stroke ☐Bleeding Tendencies ☐Tuberculosis ☐Other_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform Dr. Uyen Nguyen if I, or my minor child, ever have a change in health.

_____

Signature of Patient, Parent, or Guardian **Printed Name/Relationship** **Date**

INSURANCE:
Subscriber Name: _____
Subscriber Birth date: _____ Social Security#:_____
Relationship to Patient: _____
Insurance Company: _____ Group#:_____
Additional Insurance Coverage: _____ Group#:_____

Insurance Assignment and Release
I assign directly to Dr. Uyen Jackie Nguyen MD, Inc all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Uyen Jackie Nguyen may use my healthcare information and may disclose such information to my insurance company/companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Medicare/Medical Authorization
I request that payment of authorized Medicare/Medical benefits be made on my behalf to Dr. Uyen Jackie Nguyen, MD, Inc for services rendered by Dr. Uyen Nguyen, MD. I authorize any holder of medical or other information about me to be release to Medicare/Medical and their agents any information needed to determine these benefits or benefits for related services.

_____

Signature of Patient, Beneficiary or Guardian **Printed Name/Relationship** **Date**

UYEN JACKIE NGUYEN, MD. INC.

CONFIDENTIAL CHANNEL COMMUNICATION REQUEST

As required by the Health Information Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled.

I, _____, **(print full name)** hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. This request supersedes any prior request for confidential channel communications I may have made.

Please select all that apply. Where you list more than one communication option, indicate which you prefer.

I want you to contact me by **telephone** at _____

____ Do _____ Do not leave messages on my answering machine, voicemail

____ Do _____ Do not leave messages with any other person

I want you to contact me at the following **mailing address**:

_____

I want you to be part of the patient web portal at the following **e-mail address**: The portal allows you to view and print your labs and imaging studies online; to send messages directly to Dr. Nguyen or our staff; to request medication refills and appointments; and to update your file.

Please provide your e-mail address below:

_____

____ Check here if you agree to let Dr. Uyen Jackie Nguyen review your prescription drug history at participating pharmacies.

_____

Signature of Patient or Guardian **Printed Name/Relationship** **Date**

UYEN JACKIE NGUYEN, MD. INC.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Information Portability and Accountability Act of 1996(HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed.

I hereby authorize Uyen Jackie Nguyen, MD, Inc to use and disclose health information concerning

_____as follows:

Patient Name (please print) **Birth date**

Health information to be used or disclosed (check only one): *

[X] Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any except as specially provided below:

_____

_____

[ ] All psychotherapy notes may be released, except as specifically provided below:

_____

_____

This health information may be disclosed to:

_____

Name and address/phone number of person to use or receive the health information **Relationship**

The information may be used only for the following purposes (if you do not want to explain the purpose, write "At the request of the individual".

At the request of the individual_____

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form. This authorization is effective now and will remain in effect until revoked. I understand that I have the right to receive a copy of this authorization.

_____

Signature of Patient or Guardian **Printed Name/Relationship** **Date**

If not signed by the patient, please indicate relationship:

[ ] parent or guardian of minor patient (to the extent minor could not have consented to the care)
[ ] guardian or conservator of an incompetent patient
[ ] beneficiary or personal representative of deceased patient**
[ ] spouse or person financially responsible (where information solely for purpose of processing application for dependant health care coverage)

*Signed: _____ Date: _____

Treating Physician

**For the release of records (1) protected by the Lanterman-Petris-Short Act (LPS) or (2) containing HIV test results, a separate authorization is required for each separate disclosure. Further, the LPS Act often requires that both the patient's treating physician and the patient sign the authorization form before information may be released. Under HIPPA, an authorization for release of psychotherapy notes may not be combined with an authorization involving any other type of health information(except other psychotherapy notes).*

*** It is unclear whether the beneficiary or personal representative of a deceased patient can obtain and disclose certain records containing HIV test results.*

UYEN JACKIE NGUYEN, MD. INC.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. **Failure to provide *all* information requested may invalidate this Authorization.**

I hereby authorize the use and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated below.

1. _____ _____ _____

Name of Patient (please print name) **Date of Birth** **Social Security #**

2. **AUTHORIZE TO RELEASE RECORDS TO:**

UYEN JACKIE NGUYEN, MD
Name of Physician/Facility

18682 BEACH BLVD #110
Street Address

HUNTINGTON BEACH, CA 92648
City, State, Zip Code

714-378-1300 // 714-378-1316
Phone # // Fax #

RELEASE RECORDS FROM:

_____
Name of Physician/Facility

_____
Street Address

_____
City, State, Zip Code

_____
Phone# // Fax #

3. **SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED**
Check the box and initial which type of information is to be released and/or disclosed:

[ ] General Medical Information from_____ to _____

[ ] Information Regarding Specific Injury or Treatment from _____to _____

[ ] X-ray Reports [ ] Laboratory Results [ ] Immunization Records [ ] Billing Records—Specify

[ ] Other (please describe) _____

3A. In compliance with California Statues which require special permission to release otherwise privileged information, please release records pertaining to: ***(separate specific authorization required)***

[ ] Mental Health from _____ to _____, Patient Signature or Rep. _____, Date_____

[ ] Alcohol Abuse from _____ to _____, Patient Signature or Rep. _____, Date _____

[ ] Drug Abuse from_____ to _____, Patient Signature or Rep. _____, Date _____

[ ] HIV/AIDS Testing from_____ to _____, Patient Signature or Rep. _____, Date _____

I request that the health information released and/or disclosed pursuant to this authorization be used for the following purposes only: _____

4. DURATION: This authorization shall become effective immediately and will expire on _____/_____/_____.
If I do not indicate a date, this authorization will expire (1) year from the date of my signature.

5. SIGNATURE

_____ _____ _____

Date **Patient Signature or Patient's Representative** **Indicate your relationship to patient**

Witness: _____

REVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this authorization.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

UYEN JACKIE NGUYEN, MD. INC.

PATIENT PARTNERSHIP PLAN

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc). **These health screenings are tests that can help detect life-threatening diseases and conditions**. If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your healthcare. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

_____ _____ _____

Patient Signature **Date** Physician Signature

UYEN JACKIE NGUYEN, MD. INC.

PATIENT RESPONSIBILITIES

1. You have the responsibility to provide accurate and complete information concerning your present complaints, past medical history, and other matters relating your health.

2. You have the responsibility for making it known whether you clearly comprehend the course of your medical treatment and what is expected of you.

3. You have the responsibility for following the treatment plan established by your physician, including the instructions of nurses and other health professionals as they carry out the physician's orders including return visits.

4. You have the responsibility for assuring that the financial obligations of your care are fulfilled.

5. You have the responsibility for inquiring about information regarding Advance Directive (Durable Power of Attorney for Health Care, Natural Death Act Declaration or Living Will) from your primary care provider or your Health Plan.

6. You have the responsibility to treat all providers, office personnel and other patients respectively and courteously.

7. You have the responsibility to communicate openly with your physician so that you can develop patient-physician relationship based on trust and cooperation.

8. You have the responsibility to seek and obtain services as consistently as possible from your primary care physician.

9. You have the responsibility to take charge of your health, make positive choices and seek appropriate care when needed.

10. You have the responsibility to consider the possible consequences if you refuse to follow the physician's orders or comply with the recommended treatment.

11. You have the responsibility to keep appointments or give adequate notice of delay or cancellation.

12. You have the responsibility to read all Plan material carefully as soon as you enroll and to ask questions when necessary.

13. You have the responsibility to help your physician to maintain accurate and current medical records by being open and honest when you provide necessary information.

14. You have the responsibility to constructively express your opinions, concerns, and complaints to the appropriate people within your Health Plan

15. You have the responsibility to call your physician's office after a reasonable period of time when you have any type of laboratory test, x-ray, or pathology results pending.

I have been informed of my responsibilities and I understand them fully.

Patient Signature _____ **Date** _____

UYEN JACKIE NGUYEN, MD. INC.

ABOUT FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance we are anxious to help you receive you maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our PAYMENT POLICY.

Payment for services is due at the time services are rendered, unless payment arrangements have been approved in advanced by our office. We accept cash, MasterCard, and Visa. We will be happy to bill your insurance company, as a courtesy; however, in order to do that we must have a complete insurance form and a copy of your insurance card.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. You are responsible for making sure that the doctor you select to care for you is a physician of your insurance company contract.

We must emphasize that as medical care providers our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are YOUR RESPONSIBILITY form the date the services are rendered. We realize that temporary financial problems may affect timely payment to your account. If such problems do arise, we encourage you to contact us for assistance in the management of your account.

If you have any questions about the above information or uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

I have read all the information above. I understand and agree that regardless of my insurance status I am ultimately responsible for the balance on my account for all professional services rendered.

Patient Signature_____ **Date**_____

UYEN JACKIE NGUYEN, MD. INC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Huntington Medical Group. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you will be offered a copy of the amended notice at your next appointment.

I acknowledge receipt of the *Notice of Privacy Practices* of Huntington Medical Group.

Patient's name: _____

Signature: _____ **Date**: _____

If not signed by the patient, please indicate:

Relationship:

[ ] parent or guardian of minor patient
[ ] guardian or conservator of an incompetent patient
[ ] beneficiary or personal representative of deceased patient

Name of Patient: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Patient's Name:_____

Reason why acknowledgement was not obtained:

[ ] Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the *Notice of Privacy Practices*

[ ] Other: _____

Signature of provider representative: _____Date:_____

UYEN JACKIE NGUYEN, MD. INC.

CREDIT CARD ON FILE AGREEMENT

At Uyen Jackie Nguyen, MD INC, we have implemented a credit card policy. This policy which enables you to maintain your credit card information securely on file as a convenient method of paying for the portion of services you owe after your health plan pays its portion of your claim. **We know that you are busy and may not address your bills in a timely manner. Putting your card on file will prevent $25 late fee assessed per our billing policy.** Your credit card information will be kept confidential and secure, and charges to your card are made after your health plan makes its payment to us.

Co-pays are still due at time of the office visit.

If your insurance provider has paid their portion of your bill [or any other patient(s) you have listed on this form] and there is an outstanding balance owed, Uyen Jackie Nguyen, MD, INC, will notify you via mail and emessages. A copy of the charge will be sent posted on your patient portal. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

By signing below, I authorize Uyen Jackie Nguyen, MD, INC, to keep my signature and credit card information securely on-file in my account. I authorize Uyen Jackie Nguyen, MD, INC to charge my credit card for any outstanding balances when due.

If the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give Uyen Jackie Nguyen, MD, INC a new, valid credit card which I will allow them to charge over the telephone. Even though Uyen Jackie Nguyen, MD, INC is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card I presented.

[ ] Visa [ ] FSA/HSA/FLEX [ ] MasterCard [ ] American Express [ ] Discover

Patient's Name (Print): _____ DOB: _____

Name on Card (Print): _____

Credit Card Number: _____ Exp. Date: _____

Please fill out information below for any other person(s) you authorize this credit card for:

Patient Full Name: _____ DOB: _____

(Please Print)

Patient Full Name: _____ DOB: _____

Patient Full Name: _____ DOB: _____

The credit card will be charged at the end of the day. Would you like to receive notifications before we charge your credit card? [ ] Yes [ ] No

Phone number: _____ [ ] Call or [ ] Text

Patient Signature: _____ Date: _____

☐ Hoag Medical Group ☐ Hoag Urgent Care ☐ Hoag Physician Partners ☐ Hoag Concierge Medicine ☐ Hoag Specialty Clinic

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Patient Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (*Please circle your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
	0 +	+	+	
If total is less than 3, patient Depression Risk is complete and no need to proceed to rest of the questionnaire. If total is 3 or greater, proceed with the rest of the questionnaire.			TOTAL:	

	Not at all	Several days	More than half the days	Nearly every day
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	0 +	+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).			TOTAL:	

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Patient Signature: _____ Date: _____ Time: _____

Staff Signature: _____ Date: _____ Time: _____

QUESTIONNAIRE

Form# 8050 Rev 05/15/23

[2050]

PATIENT LABEL