

Dr. Kewa Li's Clinic

2931 Donnylane Blvd Columbus, OH 43235
Phone: (614)760-0622 ♦ Fax: (614)760-0610

PATIENT REGISTRATION FORM

Patient Name: _____ SSN: _____

(Last), (MI) (First)

Date of Birth: _____ Gender: Male _____ Female _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

Home Phone: (____) _____ Cell Phone: (____) _____ E-mail: _____

Patient Employer/School: _____ Occupation: _____

Employer/School Address: _____ Employer/School Phone: (____) _____

In case of emergency who should be noticed? _____ Phone: (____) _____

Primary Insurance Information

Name of Company _____

Phone: _____

Secondary Insurance Information

Name of Company _____

Phone: _____

FINANCIAL POLICY

Medical care and treatment can be expensive and insurance delay frustrating. To reduce these burdens, we have developed certain policies.

1. We will submit your claim for you, if you will provide accurate and complete information. As a courtesy, we will re-file the claim one more time. **YOU MUST BE AWARE, THOUGH, THAT THE ULTIMATE RESPONSIBILITY FOR YOUR FINANCIAL OBLIGATION LIES WITH YOU AND THE CLAIM NEEDS TO BE PAID WITHIN NINETY DAYS***
* We accept assignment on MEDICARE claims. Therefore, the twenty percent of Medicare's approved amount is the patient's responsibility and is due within ninety days of the MEDICARE payment.
2. All patients will be provided with an itemized bill of services rendered and charges accrued, whether at the time of service or in a monthly statement that can be used for any additional insurance you might have.
3. Please inform our staff if your insurance company has special requirements such as pre-certification, referrals, etc... We do all we can to help, but the ultimate responsibility for fulfilling special requirements rests with the patient.
4. Patients who are members of certain plans may be required to pay a co-payment. Co-payments are due at the time of service; again we do accept cash, check, master card and Visa.

CONSENT FOR USE AND DISCLOSURE OF MEDICAL INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I authorize the release of my health information regarding services rendered by the practice to my insurance company or any governmental payer, or any other persons/entities as may be reasonably necessary for billing and collection purposes. I also authorize the Practice to release medical information about me to other health care providers for treatment purposes. In addition, if the patient is a minor child, I, as a parent/guardian, authorize the release of medical information to the child's other parent, or person(s) that I have listed above as being responsible for the medical bill. I understand that this authorization to release information may include the release of personal and private medical information, if such release of information is necessary for reimbursement and billing purposes, or for purposes of subsequent treatment. Further, this authorization is valid for the disclosure of medical information contained in hard copy or electronic form including, but not limited to, electronic mail and facsimile. Finally, I understand that the practice may use and/or disclose certain information about me in order for it to carry out its various health care operations including, but not limited to, carrying out quality assurance and improvement, business planning and other efforts the practice has determined to be necessary and vital to properly conduct its operations. This consent to release medical information may be revoked in writing by me at any time and such revocation shall be effective immediately, except to the extent that the Practice has taken action in reliance upon my consent.

ASSIGNMENT of BENEFITS:

I hereby assign all medical benefits to include major medical benefits to which I am entitled, Medicare, private insurance and any other health plans to **Dr. Kewa Li, M.D. INC.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

_____ I DO; _____ I DO NOT CONSENT TO FORWARDING OF MY MEDICAL RECORDS IN THE EVENT OF REFERRAL TO ANOTHER PHYSICIAN OR UPON REQUEST BY MY FAMILY DOCTOR.

Signature: _____ (Patient or Parent if ≤ 18 years of age) Date: _____