Steven D. Chang MD Inc.

3160 Telegraph Road, Suite 102 • Ventura, CA 93003 • 805 644-7312
www.stevendchangmd.com

Dear Patient,

Welcome to our office. Please complete the attached paperwork so that we will have all the necessary information to assess and treat you.

We would like to take this opportunity to acquaint you with our office policies:

- Copayments, co-insurance, and/or unmet deductibles are collected at the time of service.
- We require a full 24 hour notice for appointment cancellations. You will be billed $35.00 without proper notification.
- We will bill you for your "patient balance" after we receive the explanation of benefits from your insurance company. Your patient balance will begin to accrue a 5% finance charge from the 30th day after your bill is issued.
- Services are not rendered on a third party basis, meaning that we cannot bill another party's auto insurance which has medical coverage.
- We do not accept assignment on Workers' Compensation claims.

We do not participate in all insurance plans. You can call the number on your card for a list of participating providers. We will be happy to bill your insurance for plans on which we are participating providers. It is imperative that you inform us of any changes to your insurance coverage (i.e. switching to a different insurance company, policy number or different plan) when scheduling your appointment. We also require a copy of your insurance card(s) when you check in for your appointment.

We will provide all information and paperwork to your insurance company, but sometimes a call is required from you to resolve issues to your account. We also ask that you respond immediately to any requests from your insurance company. If your insurance company has not paid us within 45 days, the balance owed will become your responsibility.

Signature_____ Date _____

AUTHORIZATION TO PAY PHYSICIANS / ASSIGNMENT OF BENEFITS

I hereby authorize_____ Insurance Company(s) to make payment and mail directly to Steven D. Chang M.D. Inc. at the address indicated above, as payment toward the total charges for professional services rendered.

I understand that Steven D. Chang M.D. Inc. will submit claim(s) on my behalf to my insurance company as a courtesy to me. However, I am financially responsible for the total charges of services rendered which may include services not covered or paid in a reasonable time by my insurance company(s)

Signature_____ Date _____

Print Patient Name _____

Form 3/28/2018

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Patient Information

Name:	Sex: Male Female	Birth Date:
Address:	City:	Zip:
Home Phone:	Work Phone:	Cell Phone:
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced		Age:

Employer Information

Patient's Employer:		Full Time Student: Yes No
Employer Address:	City:	Zip:
Employer Phone:	Are your medical benefits through your employer: Yes No	

Medical Insurance Information

Insurance Name:	Type: Medicare PPO POS HMO
Policy / ID #:	Subscriber's Birth Date:
Subscriber Name:	Subscriber's Plan or Group #:
Relationship to Patient:	Subscriber's Employer:

Secondary Insurance ☐ **I do not have secondary insurance**

Insurance Name:	Type: Medicare PPO POS HMO
Policy / ID #:	Group #:
Subscriber information is the same as primary subscriber information: YES NO (fill out below)	
Subscriber Name:	Subscriber's Birth Date:
Subscriber's Employer:	Relationship to Patient:

**Our office does not accept assignment or bill claims to tertiary insurance plans.*

Responsible Party

Name:	Birth Date:
Address:	Phone:
Emergency Contact Name:	**Phone:**
Next of Kin Name: **Address:**	**Relationship:** **Phone:**

I have an Optometrist: Yes No	Optometrist Name:

Referred By:_____ Friend Optometrist Specialist PCP Other

By signing below, I authorize the release of any medical information necessary to process my claim(s). I understand Steven D. Chang MD Inc. will submit a claim for me and it is my responsibility to check that Steven D. Chang MD Inc. is a provider under my insurance policy. I am financially responsible for the total charges of services rendered which may include services not covered or not paid in a reasonable time by my insurance company(s).

Signature:_____ Date:_____

Email: _____

Steven D. Chang MD Inc.

Acknowledgement of Receipt of Notice

Steven D. Chang MD Inc – 3160 Telegraph Road, Suite 102, Ventura, CA 93003
Linda Locklear – Office Manager (805) 644-7312

I hereby acknowledge that I have read or upon request received a copy of this medical practice's Notice of Privacy Practices.

Yes or No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: _____

_____

For Office Use Only:

☐ Signed form received by: _____

☐ Acknowledgment refused:

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

Form 3/28/2018

MEDICATION & PHARMACY INFORMATION

Primary Doctor: _____ **Optometrist:** _____

ALLERGIES

Do you have any **allergies** to medications? ☐ No ☐ Yes

If yes, please list medication allergies:_____

PHARMACY INFO

Mail Away Pharmacy: _____

Local Pharmacy Name: _____

Local Pharmacy Address:_____

_____

Pharmacy Phone: _____ Pharmacy Fax:_____

Please list all current medications you are taking both prescription and OTC.

Name of medication	Milligrams & Dosage	Why are you taking this medication?

Print Patient Name_____

Patient Signature_____ **Date** _____

Steven D. Chang MD Inc.
3160 Telegraph Road Suite 102, Ventura CA 93003 • Phone (805) 644-7312 Fax (805) 644-1584