Medical Wellness Center

Chen Ha, MD
9801 Anderson Mill Rd. #105
Austin, TX 78750
Tel: (512) 999-7010

Patient Information

Last Name: _____ First Name: _____MI: __ S.S.:____-___-____ DOB: ___/___/___Sex__
Address: _____Apt #:_____City:_____ State: ___ Zip:_____
Home Phone: _____ Work Phone: _____ Marital Status: S M D W S Occupation:_____
Employer: _____ Address: _____ Phone: (___) _____
Primary Insured's Name: _____ S.S.:____-___-____ DOB: _____
Spouse or Parent's Name: _____S.S.:____-___-____ Phone:(___)_____
Address (if different from above):_____City: _____ State: ___ Zip: _____
Employer: _____Address: _____ Phone: (___) _____

Insurance Information

Medicare #:_____ Effective Date: _____ Date Applied: _____
Medicaid #:_____ Effective Date: _____ Date Applied: _____
Primary Insurance: _____Group #:_____ ID #:_____
Billing Address: _____ Phone: (___) _____
Secondary Insurance: _____ Group #:_____ ID #: _____
Billing Address: _____ Phone: (___) _____
Name Insured: _____ Relationship: _____
Employer: _____
Address: _____

Emergency Contact Information

1):_____ Relationship: _____Phone: (___) _____
2):_____ Relationship: _____Phone: (___) _____

Referred by: _____ Phone: (___) _____

Assignment of Benefits

Please read: All charges are due at the time of service.

I hereby assign, transfer, and set over to Medical Wellness Center PLLC all my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information to the billing management company on behalf of Medical Wellness Center PLLC needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand this order does not relieve me of my obligations to pay such bills if not paid by my insurance company or any balance due after payment by my insurance company

_____ _____ _____
Patient Signature Date Witness Signature

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1. INDIVIDUAL PATIENT
I give my authorization to use or disclose my protected health information as described in Section 2 below.

My Name: _____ Social Security #:_____-_____-_____

Legal Responsibility

❑ If you are 18 years old or older, you are legally responsible for yourself, check this box.

❑ If you are an emancipated child or teenager and your parents no longer have custody over you, check here.

❑ If you are a child or teenager and your parents are divorced, please check this box. Below please list the names of the parent or guardian who has custody over you.

2. THE USE AND/OR DISCLOSURE
A. I understand that under the HIPAA regulations, my health information will be used and disclosed to any health care provider who is involved with my medical treatment or services, my health insurance plan, and any medical billing clearinghouse who is involved with my insurance claims fulfillment.

B. Under these new regulations the following people must be authorized by me to have access to my health information: spouse, other family members, friends, nurse or home aid, legal guardian, or other person/organization who is not involved with my medical treatment, insurance plan, or payment.

Below, please list the people/organizations that you authorize to have access to your information:

Persons/Organizations Receiving the Information:
1) Name: _____ Contact Phone: (_____) _____
Address: _____ Relationship: _____
What Specific Information to Disclose: _____
Date the Disclosure Will Expire: _____

2) Name: _____ Contact Phone: (_____) _____
Address: _____ Relationship: _____
What Specific Information to Disclose: _____
Date the Disclosure Will Expire: _____

3. CHANGING YOUR MIND ABOUT THE AUTHORIZATION
I understand that I may revoke this authorization at any time by giving written notice to your Privacy Officer.

4. METHOD OF CONTACT
I authorize the office of Medical Wellness Center PLLC to contact me the following manner:
_____ Home Phone: (_____) _____ _____ OK to leave a message with detailed information
_____ OK to mail my home address _____ Leave a message with a callback number only
_____ Work Phone: (_____) _____

5. STATEMENT OF UNDERSTANDING
I have reviewed and I understand this Authorization. I also understand that my health information will be used or disclosed to certain business associates of Medical Wellness Center PLLC, who are part of the health care process. These business associates will also keep my health information confidential.
By: _____ Date: _____
(Patient)
Or By: _____ Date: _____
(Patient's Representative)