ROBERT C. HSIEH, M.D., P.A.
6510 Kenilworth Avenue, Suite 1300
Riverdale, Maryland 20737
www.roberthsiehmd.com

PATIENT REGISTRATION

*** PLEASE PRINT CLEARLY ***

Telephone #301-699-1166

Patient Name	First	Middle	Last	Date of Birth	Age

Home Address	Apt No.	City	State	Zip Code

Occupation	Social Security No.	Marital Status ☐S ☐M ☐D ☐W	Sex	Home Phone

Employer	Address	Work Phone
		Cell Phone

Spouse/Parent/Guardian Name	Spouse/Parent/Guardian Employer	Spouse/Parent Work

Spouse/Parent/Guardian Address

Emergency Contact	Relationship	Home Phone	Work Phone

Referred By	Primary Care Physician	Telephone

Pharmacy Name & Phone No.	Financially Responsible Person ☐ Patient ☐ Spouse ☐ Parent ☐ Other	Name (if different from patient)

Financially Responsible Persons Address (if different from patient)	Home Phone	Work Phone

* BILLING AND INSURANCE INFORMATION *

PRIMARY INSURANCE INFORMATION

Insurance Co. _____

ID# _____

Group# _____

Policy Holder's Name _____

Policy Holder's DOB _____

SECONDARY INSURANCE INFORMATION

Insurance Co. _____

ID# _____

Group# _____

Policy Holder's Name _____

Policy Holder's DOB _____

Assignment of Benefits / Information Release: I, _____, the undersigned authorize payment of medical benefits to Robert C. Hsieh, M.D., P.A. for any services provided by the physician. I understand that I am financially responsible for any amount not covered by my Insurance Company. I also authorize you to release to my Insurance Company information concerning health care, or treatment provided to me. This information will be used for the purpose of evaluating and administering claims and benefits.

I certify that the above information is accurate to the best of my knowledge.

_____ _____

Patient, Parent, or Guardian Signature (if child is under 18 years old)

Date

Robert C. Hsieh, M.D., P.A.
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Patient Financial and Practice Policies

- The patient must provide current, accurate billing/patient information. Inaccurate information will result in all charges for services becoming the sole responsibility of the patient/responsible party. Patients must notify the practice of any changes in information (address, insurance, and phone numbers) and provide insurance cards at each visit for verification.
- If your insurance requires a referral from your PCP, it must be presented at the time of service. Failure to do so will result in appointment cancellation.
- Copayments are to be paid at the time services are rendered. Deductibles are billed to the patient once the insurance has processed the claim fully.
- Self-pay patients: We welcome patients without health insurance. All services must be paid in full at the time of service.
- It is the responsibility of the patient to pay any outstanding bills promptly. Once an account becomes delinquent , it will go to our collection agency.
- **REFRACTION POLICY: Refraction is the determination to see if there is a need for corrective eyeglasses or contact lenses using a phoropter, see photo below. It is an essential part of the eye examination. Most insurance plans, including Medicare, do not cover the refraction. Our fee for refraction is $55.00 and this is collected at the time of service. Should your plan pay for the refraction after the fact, we will reimburse you accordingly.**

Additional fees:

- The fee for completion of the Maryland MVA Vision Certificate Form is $20.00
- The fee for returned check is $35.00
- The fee for completion of any form pertaining to employment, disability, etc. is $30.00
- We charge a fee for copying medical records. The State of Maryland allows a fee for copying records not to exceed .76 cents for each page, plus the actual cost of postage and handling. Preparation fee of $23.00, if the records are sent to another provider. The federal HIPAA regulations do not allow a charge for a preparation fee for records provided directly to the patient. A medical release form must be completed and signed by the patient before any records will be copied, faxed or released.

I have read and understand the above policies.

Patient Signature: _____Date:_____

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Acknowledgement of HIPAA Privacy Notice and Disclosure Authorization

Patient Name: _____ **DOB:** _____

By signing this form, you acknowledge that Robert C. Hsieh, M.D., P.A. has provided you with access to a copy of its Health Insurance Portability and Accountability Act (HIPAA) Privacy Notice, which explains how your health information will be handled in various situations. By law, we are required to have you sign this form annually or when any of the contact information that you wish for us to communicate with regarding your health information has changed.

Please specify by checking the appropriate answer below if we may speak with and/or leave health-related information (e.g. billing issues or other doctor-patient communications) on:

	Provide phone number/email below:	**Please circle one**
Home Answering Machine	_____	Yes No
Work Voicemail	_____	Yes No
Cell Phone Voicemail	_____	Yes No
Personal Email	_____	Yes No
Relative or other person		Yes No
Name	_____	
Phone	_____	
Relative or other person		Yes No
Name	_____	
Phone	_____	

Please note that if the above section is not completed, we will assume that we have your approval to contact you using any one of these methods. (Pt initials) _____

The practice has provided me access to its HIPAA Privacy Notice. I understand I may request a copy for my personal use.

I acknowledge that I have read, understand and agree to the above.

Patient's Signature: _____ **Date:** _____

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Patient Medical History Form

Please read and complete each section carefully. Questions? Please ask a friendly and helpful member of our staff...

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Please List ALL CURRENT medications and dosages...

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list ANY drug reactions and/or allergies...

☐ NONE

_____
_____
_____
_____
_____
_____
_____
_____

Latex Allergy? YES NO
Pacemaker? YES NO
Defibrillator? YES NO
Sleep Apnea? YES NO
Aspirin? YES NO

MEDICAL HISTORY (check and circle all that apply)

☐ **None**
☐ **Cancer** _____
☐ **Cardiovascular** High BP Chest Pain CHF Irregular Heartbeat High Cholest. Pacemaker Defibrillator Valve Problems
☐ **Endocrine** Diabetes Thyroid Imbalance
☐ **Kidney Disease** Blood in Urine Pain on Urination Renal Failure
☐ **Liver Disease** Jaundice Cirrhosis Swelling Pain
☐ **Musculoskeletal** Arthritis Lupus Joint Pain Muscle Aches Blood Clots
☐ **Neurological** Stroke Weakness Numbness Dizziness Seizures
☐ **Respiratory Disease** Asthma COPD SOB Wheezing Cough
☐ **Surgical History** _____

EYE HISTORY (check and circle all that apply)

☐ **None**
☐ **Cataracts**
☐ **Crossed Eyes**
☐ **Diabetic Eye Disease**
☐ **Double / Blurred**
☐ **Dry Eye(s)**
☐ **Eye Infection**
☐ **Eye Injury**
☐ **Eye Pain**
☐ **Glaucoma**
☐ **Halos / Flashes / Floaters**
☐ **Headaches**
☐ **Loss of Vision**
☐ **Macular Degeneration**
☐ **Retina Problems**
Other _____

FAMILY MEDICAL HISTORY (check and circle all that apply)

☐ **Cancer** _____ Relationship
☐ **Cardiovascular** High BP Chest Pain CHF Irregular Heartbeat High Cholest. Pacemaker Defibrillator Valve Problems Relationship
☐ **Endocrine** Diabetes Thyroid Imbalance Relationship
☐ **Neurological** Stroke Weakness Numbness Dizziness Seizures Relationship
☐ **Respiratory Disease** Asthma COPD SOB Wheezing Cough Relationship

FAMILY EYE HISTORY (check and circle all that apply)

☐ **Cataracts** Relationship
☐ **Diabetic Eye Disease** Relationship
☐ **Glaucoma** Relationship
☐ **Loss of Vision** Relationship
☐ **Macular Degeneration** Relationship
☐ **Retina Problems** Relationship

SOCIAL HISTORY

Smoker? _____ _____ If YES, amount _____ per day.
YES NO

Alcohol Use? _____ _____ If YES, amount _____ per week.
YES NO

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____
☐ Robert C. Hsieh, M.D.