sf-neurology™

San Francisco Neurology and Sleep Center
三藩市神經睡眠中心

950 Stockton Street Suite 368, San Francisco, CA 94108 • Tel: (415) 666-2536 • Fax: (415) 666-2500

PATIENT INFORMATION 個人資料

Last Name (姓)_____ **First Name** (名)_____ **M.I.**_____

Date of Birth (出生日期) _____ **Gender** (性別) ☐ Male (男) ☐ Female (女)

SSN# (工卡號碼)_____ **Language** (語言) ☐ English ☐ Cantonese (粵) ☐ Mandarin (國)

Marital Status 婚姻狀況 ☐ Single (單身) ☐ Married (已婚) ☐ Other (其他)_____

Address (地址) _____

Home Phone (電話) _____ **Cell Phone** (手機) _____

Primary Care Doctor (家庭醫生)_____ **Referrer** (轉介人) _____

HEALTH INSURANCE INFORMATION 醫療保險資料

Primary Insurance (保險)_____ Policy # (保險號碼)_____

Secondary Insurance (保險)_____ Policy # (保險號碼)_____

PATIENT ACKNOWLEDGEMENT 病人須知

1. I understand I am financially responsible for the charges for the services, which are not covered by my medical insurance. 我了解如果我的健康保險不承擔我所有或部分的醫療服務費，我需要承擔此費用.
2. I understand that it is my obligation to provide and update my medical insurance information. 我了解我有責任提供及更新準確的醫療保險資料.
3. I authorize San Francisco Neurology and Sleep Center to provide medical treatment for the above named patient. 本人現授權與三藩市神經睡眠中心給上述病人提供醫療服務.
4. I authorize the release of correspondence and/or medical records to other providers involved in my care. 本人現授權並允許將病人的病情資料告訴與治療有關的其他醫生.
5. I authorize the release of medical records necessary to process insurance claims. 本人現授權並允許將病人的病情資料告訴保險公司，以便由保險公司付費.
6. I authorize any holder of medical information about me to release records to San Francisco Neurology and Sleep Center. 本人現授權並允許將病人病情資料告訴三藩市神經睡眠中心，以便治療.

ACKNOWLEDGEMENT OF RECEIVE OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed and/or received a copy of Dr. Joy Meng's notice of Privacy Practices. This notice describes how Dr. Joy Meng may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. I understand that The Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of The Notice of Privacy Practices. I understand a copy of the most current version of this practice's Privacy Practices in effect will be posted in the waiting area.

我知道我的健康信息是受保護的. 我知道該診所最新的健康信息保護條例陳列在病人候診室. 我有權獲得并閱讀. 診所會按照該健康信息保護條例處理與保護我的健康信息.

Signature (簽名)_____ Date (日期)_____