ORANGE COUNTY KIDNEY

Sandeep S. Dang, M.D.
Philip S. Yang, M.D.
Son T. Dinh, M.D.
Essam Mostafa, M.D.

Tel: (714) 751-0995
Fax: (714) 751-5606
www.orangecountykidney.com

New Patient Checklist

Please bring the following with you on your scheduled appointment:

Your insurance card_____ ○

Medications or a list of your medications (if any)_____ ○

Test results, such as CT Scans, blood test, ultrasounds, etc. (if any)_____ ○

New patient packet (includes *Patient Information*, *HIPAA*, & *Office Policy*) _____ ○

If you have any questions, feel free to call us Monday-Friday from 8:00am-5:00pm.

Thank you! We look forward to seeing you at our office!

○ 17150 Euclid St., Ste. 200
Fountain Valley, CA 92708

○ 320 Superior Ave., Ste. 350
Newport Beach, CA 92663

○ 1211 W La Palma., Ste. 707
Anaheim, CA 92801

○ 12666 Brookhurst St., Ste. 130
Garden Grove, CA 92840

○ 19582 Beach Blvd., Ste. 314
Huntington Beach, CA 92648

○ 15825 Laguna Canyon Rd., Ste. 202
Irvine, CA 92618

○ 5742 Beach Blvd., Ste. A
Buena Park, CA 90621

Appointment Date: ____/____/___ Time: _____ AM/PM

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PATIENT INFORMATION

Patient Information

Last Name _____ First Name _____ M.I. _____

Sex M F Birthdate _____ Age _____ SS# _____

Address _____

City _____ State _____ Zip Code _____

Home Ph _____ Cell Ph _____

Email _____

Emergency Contact

Name _____ Relationship _____

Phone _____

Primary Care Physician: _____

Referred By: _____

Insurance Information (Office needs a copy of Insurance Cards)

Insurance Name _____

Subscriber Name (exactly as it appears on card) _____

Member ID _____ Group# _____

Social Information

Ethnicity _____ Preferred Language _____ Race _____

Authorization to release information: I hereby consent to releasing information for the purpose of treatment, payment, or health care operations.
Assignment of benefits: I hereby authorize my insurance benefit to be paid directly to my physician.
Consent for treatment: I hereby consent to necessary examination procedures and/or treatment by my physician, his/her assistants, designees as is necessary in his/her judgment.

Date _____ Signature _____

Name _____

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name: _____ Date of Birth: _____
First Middle Last

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct ***Orange County Kidney,*** located at ***17150 Euclid St, Ste 200, Fountain Valley, CA 92708,*** to disclose my health information during the term of this Authorization to the recipient that I have identified below:

Recipient of Records: _____

Address for Delivery of Records: _____

Information to be disclosed: This authorization permits the above named provider to disclose the following medical records:
☐ **All of my health information** that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the above-named health care provider may hold.
☐ **All of my health information** described above **except** for the following:

_____

☐ **Only the following records** or types of health information: (Insert dates of treatment, types of treatment or other designation.)

_____

Term: This Authorization will remain in effect for one (1) year from the date this authorization is signed
Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.
Revocation: I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.
Questions: I may contact my health care provider for answers to my questions about the privacy of my health information at my health care provider's regular office telephone number. I understand that I have right to receive a copy of this authorization from my health care provider.
Photocopy: A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original.

☐ I do not wish to authorize disclosure of my health information to any recipient at this time.

_____ _____ _____ _____
Signature Printed Name Date Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____
Signature of Personal Representative Name of Representative Legal Relationship Date

_____
Signature of Witness

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OFFICE FINANCIAL POLICY

Orange County Kidney is committed to providing the highest level of medical care to our patients. To ensure that our patients understand our billing process, we ask that you read our office financial policies listed below:

CANCELLATIONS:
Any cancellations require 24 hours notice. There will be a $15.00 charge for failing to call and cancel 24 hours before your appointment. This charge is not reimbursable by your insurance.

DENIED CLAIMS:
Our billing staff will not become involved in disputes between you and your insurance company regarding uncovered charges, coordination of benefit issues, eligibility issues, pre-existing conditions or any other matter, which causes the claim to be denied. Should your claim be denied for any reason, the claim will become your responsibility and payment will be expected immediately.

INSURANCE PARTICIPATION:
We try to participate with as many major insurance companies as possible. However, it is the patient's responsibility to ensure that the physician he/she is seeing participates with their insurance company. Any patient treated by a non-participating physician will be responsible for any deductibles or charges imposed by their insurance company.

MEDICAL RECORDS AND X-RAYS:
We charge a nominal fee to provide patients with copies of their medical records and/or x-rays. Please ask our front office about the fee associated with the copies that pertain to you.

MISCELLANEOUS CHARGES:
All returned checks will be assessed a $25.00 returned check fee in addition to the original charge.
We charge nominal fees when our doctors complete and sign additional forms outside of patient care, charges vary.

PATIENT RESPONSIBILITY:
Without exception, it is the responsibility of the patient to pay his/her co-payment and any unpaid portion of the deductible at the time of service. If you are unable to pay your co-pay at the time of service, we reserve the right to reschedule your appointment at our next available appointment time. Any additional co-payments, deductibles and/or co-insurance will be billed to the patient as indicated by your insurance carrier. Your insurance company can provide you with an explanation of your benefits for your visit. All patients without insurance must pay in full before services are rendered. Finally, It is the patients responsibility to inform and provide us with a copy of your new insurance, should your insurance coverage change.

REFERRALS:
All of our patients requiring the services of outside specialists or labs will be given a referral depending on their health plan. All outside patients requiring the services of any of our specialists must bring a referral from their Primary Care Physician or as required by their healthcare plan. Please contact your insurance company to find out if a referral is required. Outside specialists and labs have their own billing procedures and policies; please contact them, for more information.

REFUNDS:
All refunds will be processed within 6-8 weeks after the overpayment is discovered on the patient's account or at the time the refund is requested. Patients who have insurance but made a partial payment, or made payment in full, will not be refunded until payment in full is received from their insurance company.

By signing this form, I agree to the policies that have been put in place by Orange County Kidney.

Patient Name _____ Patient Signature _____ Date _____