Suh & Suh, M.D., Inc **Se Mo Suh, M.D., Ph.D. Philip J Suh, M.D.**
725 Kapiolani Blvd. #C114, Honolulu, HI 96813 Tel: (808) 946-1414 Fax: (808) 946-1515

Patient Name _____ Birth Date:_____/_____/_____
환자이름 Last name성, First namd이름 생일 월 일 년도

Gender M____ F_____ Minor( ) Single( ) Married( ) Divorced( ) widowed ( )
성별 남 여 미성년 미혼 기혼 이혼 사별

Parent or Guardian Name (If minor)_____ Relation_____
보호자 이름(미성년자일 경우) 관계

Address
(주소)_____

_____

_____

_____

_____

Email _____ SSN 소셜넘버 _____

Telephone Cell Phone(핸드폰) _____
I do not want to receive reminder texts, please initial here( )
(다음예약 알림 문자를 받고 싶지 않으시면 괄호안에 사인하십시오)

Insurance : Subscriber_____ DOB _____

Emergency Contact(응급 연락처)

Name(이름) _____ Relation(관계) _____

Cell Phone (휴대폰) _____

Signature (서명)_____ Name _____
Parent or legal guardian **if** minor(미성년인 경우 부모 혹은 보호자의 서명) 이름

Date _____ Relation _____
날짜 환자와의 관계

Medical History (의료기록)

Patient Name : _____ Date of Birth____/_____/_____
환자이름 생년월일 월 일 연도

Allergy(알러지)_____
_____
_____

Medication(복용하시는약)_____
_____
_____
_____
_____

Past Medical History(과거병력)_____
_____
_____
_____
_____

Past Surgical History(과거수술기록)_____
_____
_____
_____
_____

Family History(가족병력기록)_____
Father:_____
Mother:_____
Siblings:_____
Raletives:_____

Other(기타):_____
_____

Signature(서명):_____ Today's date:_____

SUH & SUH, M.D. Inc. OFFICE POLICIES

725 Kapiolani Blvd. #C114, Honolulu, HI 96813 Tel: (808) 946-1414

Office Hours:

Monday to Friday: 9:00AM to 4PM - Lunch hours: 12PM - 2 PM
Wednesday and Saturday: 9:00AM to 12:00PM
Closed for Sundays and Holidays

After hour & Emergencies: For a serious emergencies call 911. You may reach Physician's Exchange at 524-2575 after office hours.

Cancellations: Please call within 24 hours prior if you are unable to keep your appointment.

Treatment of minors: Patients under the age of 18 must be accompanied by a responsible adult or have written permission for treatment from a parent or legal guardian.

Changes in address, billing or contact Information: Please notify our office in writing of any changes of address, telephone, billing (Insurance) or contact information. In case of Emergency, it is imperative that we have the most current information on file.

Copay: For the first few visits, an estimated copayment ($20) will collected at the end of each visit. Once the copay amount is finalized with the insurance company, any discrepancy will be recorded in your account and added to (or deducted from) the payment for your next visit. In some cases your copay may be higher than the insurance card or insurance statements indicated amount because of tax.

Refill Request: Please leave your refill request to our phone message box. Within 48 hours, We will either fax your prescription to the pharmacy or will contact you in case we are not able to authorize the refill.

Medical Records Release You may request a copy of your medical record.
Transfer to another physician. A records release form must be filled out in order for our records department to transfer your records to another doctor.

Dismissal: If you are "dismissed" from the practice it means you can no longer schedule appointments, get medication refills, or consider us to be your primary physician. You need to find another doctor or go to a clinic or urgent care facility for follow up.

Common Reasons for Dismissal

- Failure to keep appointments, frequent no-shows
- Non-compliance, which means you won't follow physician instructions
- Abusive to physician or staff
- Failure to pay your bill

Dismissal Process

We will send a letter to your last known address, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on this letter, we will see you. After that, you must find another doctor. We will forward a copy of your medical records to your new doctor after you let us know who it is and sign a release form.

Patient's Name: _____ Sign:_____ Date:_____
Patient or authorized representative

In case you signed on behalf of the patient, Your Name: _____
[ ] Parent [ ]Legal Guardian [ ]Court Order [ ]Other

SUH & SUH MD, INC

A COPY OF THIS FORM WILL BE PROVIDED AT YOUR REQUEST. PLEASE INFORM THE RECEPTIONIST.

AGREEMENT FOR FINANCIAL POLICY

We would like to thank you for choosing Suh & Suh, M.D.Inc as your medical provider.
The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

No Insurance: Payment will be due at the time of service.
Insurance: Although we are contracted with most of insurance companies, it is your responsibility to make sure that our physician is in your plan. It is also your responsibility to know your insurance benefits. We ask that at the time of your appointment you bring your insurance card and a photo ID.You will be responsible for all fees that are not covered by your insurance, including co-pays,co-insurance, deductibles and non-covered services at the time of service.
If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
Co-pay : The co-pay cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. We strive to be as accurate as possible in calculating your responsibility but, with so many variations in policies and fee schedules, we are not always exact. You may receive a statement from our office for any balance due. For your convenience we accept cash, checks, credit cards. Payment are also accepted by phone.
No Show : Patients who do not show up for their appointment without previous 24 hour cancellation will have a "No Show" appointment recorded in the chart. We will remind you when the first no show has occurred. Following the first missed appointment, there will be a $35 fee billed to you per "No Show." Multiple "No Shows" will be cause for patient dismissal.
Return Check: There will be a charge of $ 25.00 assessed for any check returned by your bank for any reason.
Medical Records: We will provide you a copy of your medical records upon request and for a fee. You will need to sign a letter of release prior to having them copied. Please allow up to 30 days for this request to be processed.
Medical Forms: There will be a charge of $25.00 for the completion of medical forms or you may be required to schedule an appointment. Payment is due at the time that you pick-up these forms. Please allow 4-10 days for the completion of these forms.
Billing: If you receive a bill from us, it is because we believe the balance is your responsibility. Please contact your insurance company first, if you think there is a problem. If you have any questions about your bill, please call our billing department immediately. If you cannot pay your entire balance, please call to make payment arrangements.
Collections: Balances over 120 DAYS due may be sent to a collection agency unless other arrangements have been made. Your doctor will be notified and you may be subject to dismissal from the practice.

Acknowledgement
I have read and understand the financial policies above. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Name_____ Sign_____
Date_____

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HIPAA Authorization For Use or Disclosure of Health Information

(required by the Health Insurance Portability and Accountability Act - 45 CFR Part 160 and 164)

Patient's Name _____ **Birth Date** _____
환자이름 생일

I authorize the use and/or disclosure of my health information for purpose of continuity of medical care, insurance claims, and personal records (including legal action), and health care operation. (나는 나의 의료기록을 치료목적이나,보험청구,개인용 기록, 치료운영의 목적으로 사용하거나 공개할수 있도록 허락합니다.)

I understand if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulation then the information may be re-disclosed, and would no longer be protected.(나는 만약 나의 건강정보가 연방 "사생활보호법"에 저촉되지 않는 이에게 공개된후엔, 그 정보에 대해서는 더 이상 보호되지 않는다는 것을 이해합니다.)

I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission.(이 승인서의 취소를 원할때는 언제든지 서류를 제출함으로써 기능하다는것을 이해합니다.(단, 이 승인서 원본에 의거하여 이미 열람된 사항은 해당되지 않음)

I understand that treatment by any party may not be conditioned upon my signing of this authorization and that I may have the right to refuse to sign this authorization. (나는 이 허가서에 서명하지 않을 권리가 있으며, 그로써 본인이 진료를 받거나 진료받을수 있는 권한에 영향을 미치지 않음을 이해합니다.)

1. **When Philip Suh MD/Se Mo Suh MD to use or disclose health information, they can disclose all my health information**. This medical records may contain information about AIDS, Physical or sexual abuse, alcoholism, drug abuse, sexually transmitted disease, abortion, or mental health treatment. 위와 같은 목적으로 나의 의료기록의 사용과 열람을 할 경우 그 의료기록에는 에이즈, 육체적 또는 성적학대, 알콜중독,마약,성병,임신중절,정신병력등이 포함될수 있습니다.

2. **This Authorization expires 3 years after my last office visit**.

3. **Acknowledgement of Receipt of Notice of the Use and Disclosure of Protected Health Information for Suh & Suh,M.D., Inc.**

   I have read and understand the Notice of the Uses and Disclosure of Protected Health Information. I received a copy of this Notice of Privacy Practice. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practice will be available at each appointment. 나는 개인 건강정보의 사용과 공개에대한 공고사항을 읽고, 이해했습니다.이 병원의 사생활 보호법에 관한 공지서를 받아 보았으며,환자 대기실에 공지서가 계시되어 있고 또한 개정된 공지서 사본은 방문시마다 제공될수 있음을 알고있습니다.

4. **Signature of patient** _____ **Date** _____/_____/_____
   or authorized representative 환자 또는 승인된보호자 서명 (환자가 미성년이거나 서명할수 없는 경우) 날짜

Authority of representative to sign on behalf of the patient

(Name):이름_____
[ ] Parent (부모) [ ]Legal Guardian (법적 보호자) [ ]Court Order(법정명령) [ ]Other(기타)