Chinese Medicine& Acupuncture Healing Center / IUM Medical Center
20432 Silverado Ave. #1, Cupertino, CA 95014

PATIENT REGISTRATION (Please print and complete in full) New Patient ☐ Established Patient ☐
T Today's Date:

Patient Information:

Name: Last: _____ , First:_____ Middle Ini:_____

DOB: _____ Age:_____ Sex:____ SSN: _____-_____-_____

Status: Married__ Single __ Other__ D/L or ID: _____

Address:_____
Street City State Zip
Phone: (Home) _____ (Work):_____
(Cell) _____ WeChat ID: _____
Email:_____.____

Emergency Contact: Name: _____ Relationship: _____
Phone: _____ Email: _____

Referred to our Clinic by: _____

Employment Status: Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student ☐
Occupation: _____ Employer's Name: _____

Physician's Name: _____
PCP's address: _____
PCP's phone: _____ Last Office Visit Date: _____

INSURANCE:
Primary Insurance Company: _____
Insurance Billing Address: _____
Policy Holder's Name: _____ Relationship: _____
Policy # / ID#: _____ Group #: _____

Insurance Responsibility Statement:
Having insurance is not a substitute for payment. Many companies have fixed allowance or percentages based on your contract with them, not with our clinic. It is your responsibility to pay the deductible, co-payment, and any other balances not paid by your insurance. We will assist you in billing your insurance company as much as possible. However, you are responsible for your bill.

Assignment and Release:
I hereby assign my insurance benefits to be paid directly to the provider of service. I understand that I am financially responsible for any non-covered service. I also authorize the provider to release any information required to process any claims.

Print Patient's Name: _____(18 or older, or Guardian)

Signed: _____ Date: _____

HIPAA NOTICE OF Privacy Practice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review It carefully.

This notice of Private Practices describes how ADCMC may use and disclose my protected health information (PHI).

ADCMC may use and disclose my PHI only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating or managing health care and related services by one or more health care providers.

- Payment means such activities as obtaining reimbursement for services, confirming coverage and billing activities.

- Health care operations include the business aspects of running our practice, such as conducting quality assessment, employee review activities, licensing, auditing or arranging for other business activities. I have the following rights with respect to my PHI, which I can exercise by presenting a written request to the privacy officer. These rights include:
  - To request restrictions on certain use and disclosures of PHI.
  - To inspect and copy PHI.
  - To amend my PHI.
  - To receive an accounting of disclosures of PHI.
- To obtain a paper copy of this notice from ADCMC upon request. ADCMC required by law to maintain the privacy of, and provide individuals with, this notice of the legal duties and privacy practices with respect to PHI. Signature below is only an acknowledgment that I have received this notice of ADCMC privacy practices.

_____ _____

Patient/Guardian signature 病人(父母或法定監護人)簽名 Date 日期