Catherine Chang, M.D.
1401 Avocado Avenue, Suite 710
Newport Beach, CA 92660
Phone (949) 717-6755, Fax (949) 717-6859

New Patient Packet

Welcome to our office! Thank you for choosing us to participate in your healthcare. We look forward to serving you.

Prior to your appointment

- Please complete the attached New Patient paperwork. Be sure to read the Notice of Privacy Practices and Financial Policy prior to completing the acknowledgement.

- Your will receive a phone call from our staff the day before your appointment reminding you of your appointment time.

- If for any reason you are unable to keep your confirmed appointment, please call our office to reschedule your visit.

- Note our telephone hours are: 9:00am – 12pm and 2:00pm – 5:00pm M-F.
  Our phone number is 949-717-6755.

The day of your appointment

- There are additional steps to the registration process that must be completed at the office on your first visit, so please be sure to arrive 15 minutes early with your paperwork completed so that you can make your appointment time.

- Bring your insurance card(s) or legible copy as well as an identification card. If for any reason you do not have a copy of your insurance card, please contact your insurance carrier prior to your arrival and bring proof of eligibility with you.

- Co-payment required by your insurance company or out of network charges will be due at the conclusion of your appointment.

Thanks again for choosing us!

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Thank you for choosing us as your health care provider. We ask that you carefully read the attached copes of our policies prior to agreeing to them. If you have any questions about these policies, a staff member will be happy to explain them to you.

By signing below you are acknowledging that you have received, read and agree to the following:

_____ Financial Policy (attached)
Initials I have read the Financial Policy. I understand and agree to this Financial Policy.

_____ Notice of Privacy Practices (attached)
Initials I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

Patient Signature Printed Name Date

I authorize the release of my patient health information to the following personal contacts (spouse, child, sibling, assistant, etc.) I understand it is my responsibility to notify the office of any changes in the information below.

_____
Name Relationship

_____
Name Relationship

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Financial Policy

Missed / Cancelled Appointments
A $25.00 fee will be charged for all missed appointments. It is our policy that appointments must be cancelled within 24 hours of your appointment. A $25.00 fee may be charged for appointments cancelled with less than 24 hours notice.

Insurance Billing
PPO Plans (with which we are contracted) :All co-payments are due at the time of service. A $10.00 billing fee will be charged every time a statement is sent to collect a co-payment. Your co-insurance and unmet deductible is your responsibility and payment is due at the time of treatment. If it is determined that you are not eligible for health plan coverage at the time of service, you will be responsible for payment of all services provided.

Out of Network Insurance policy (insurance plans with which we are not contracted):You are responsible for payment of the office visit in full at the time of service. We will provide you with a copy of the superbill after payment is received so that you may bill your insurance company.

Usual and Customary Rates
Our Practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Cash patients
All services must be paid in full at time of treatment. Our office can provide you with an estimate of the cost of treatment prior to your visit with the physician.

Returned Checks
A $35.00 fee will be charged for any returned checks. We will be unable to accept your check for any services thereafter.

Delinquent Payments
If delinquent payments have not been made within 3 months, I agree to pay a 100% billing fee which is to be added to my account before it is sent to the collection agency.

Medical Records
All Medical Record requests are subject to a clinical preparation fee of $35.00. The cost of shipping and handling will be added if applicable.

Prescription Refills
Written prescriptions are given at the time of an office visit only. If you need a refill prior to an office visit, it will be called to a local pharmacy. A $10.00 fee may be charged for refilling routine medication between office visits. Your physician will give you enough refills of all your routine medication to last until they want to see you again. (Please be aware of your medication needs at every office visit to prevent this from occurring). Please allow 48 hours for the office to process your prescription refills. Please note: medications will not be refilled over the weekend or on holidays.

We accept Cash, Checks, Visa, Mastercard, Discover, and American Express.

Patient Registration Information

Please PRINT and COMPLETE all sections below

Last Name: _____ First Name:_____ M. I. ____

Date of Birth: _____ /_____ /_____ Social Security # _____ - _____ - _____ Gender: M F

Address: _____Apt. #_____

City: _____ State: _____ Zip: _____

Primary Phone: ( ) _____ Cell Phone:( ) _____

Email Address: _____

Emergency Contact : _____ Phone: _____
(someone not living with you)

Billing Information

Primary Insurance Name: _____

Id# _____ Group # _____

Secondary Insurance Name: _____

Id# _____ Group # _____

ASSIGNMENT AND RELEASE

Patients who carry medical insurance should remember that professional services are rendered and charged to the patient, not to the insurance company. To avoid any misunderstandings, it is best to learn beforehand what type of coverage you have. We will be happy to bill your insurance for you (in-network only) if you provide us with the correct billing information. Please remember a bill is ultimately the patient's responsibility.

I hereby authorize payment directly to **CATHERINE CHANG M.D.** for medical services rendered. I understand that I am financially responsible for any balance not covered by my insurance carrier. I authorize the doctor to release all information necessary to secure the payment of benefits.

Signature: _____

Date:_____

Health History

NAME:_____DOB:_____Date:_____
Current problem:_____
Allergies to medications:_____
Medications that give you side effects:_____
Current medications (include dosages and frequency) or attach list:_____
_____
_____
List surgeries (type and year):_____
_____

SOCIAL HISTORY: (please circle)
smoke ___ pack for ____years currently does not smoke, quit in ____
Don't drink or currently drinks ___ per week or ___ per day
Recreational drugs: no yes
Status: married single widowed divorced Occupation:_____
Exercises :____ days a week, type_____
FAMILY HISTORY: (please circle and indicate any medical problems)
Mother: alive-conditions:_____
deceased- cause:_____
Father: alive-conditions:_____
deceased- cause:_____
Besides your parents, have any other blood relative ever had:
CANCER of the: bladder, breast, cervical, colon, kidney, lung, melanoma, ovaries, pancreas, prostate, stomach, thyroid, uterus or other (please list):_____ OR

alcoholism, asthma, colitis, coronary artery disease, dementia, depression, glaucoma, heart disease, hepatitis, high blood pressure, high cholesterol, hypothyroidism, kidney failure, osteoporosis, Parkinsons, sleep apnea, stroke or list other_____

VACCINES: (please list the year if you remember)
Flu_____Hep A_____HepB_____HepA/HepBcombo_____HPV_____
Meningitis_____ Tetanus_____Tetanus with Whooping Cough _____
Pneumonia_____
Typhoid _____Tuberculosis skin test_____Shingles_____Yellow Fever_____

SYSTEM REVIEW: (Please circle if you are experiencing these symptoms)
General: weight gain, weight loss, difficulty sleeping, fatigue, difficulty concentrating, loss of pleasure in previously fun activities, anxiety, depression

ENT: headaches, dizziness, vision problems, sinus drainage, allergies, ear pain, decreased hearing, ringing in the ears, hoarseness

Neck: stiffness or pain

Respiratory: cough, wheezing, shortness of breath, coughing up blood

Cardiac: chest pain, palpitations, swelling in ankles, shortness of breath while lying down, shortness of breath with exertion

Endocrine: cold intolerance, hair loss, increased thirst

Gastrointestinal: change in bowel movements, blood in stool, black stools, heartburn, diarrhea, constipation, trouble swallowing, nausea, vomiting, abdominal pain

Hematologic: easy bruising, easy bleeding

Neurologic: tremor, numbness, tingling, muscle weakness, memory loss, fainting

Musculoskeletal: back pain, leg cramps at night, leg cramps with walking, significant pain from arthritis

Skin: new rashes, worrisome new moles

Urinary: urinary infection, kidney stones, leaking urine, blood in urine, urinating frequently

Women only: cramps, hot flashes, dryness, heavy bleeding, breast lumps

Men only: difficulty starting stream, difficulty with erection, urinating more than twice at night

FOR WOMEN : PLEASE FILL OUT THE FOLLOWING:
Last menstrual period:_____Menopause at age:_____Last mammogram:_____Lastpap:____

Select one: I have been on hormones since_____**OR** I used to be on hormones but stopped in _____ (year) **OR** I have never been on hormone replacement therapy.
List number of Pregnancies:___Births:____Other:_____

Have you ever had: (please circle) abnormal pap smears, breast biopsies, D and C, endometrial biospy or polyp or hyperplasia, endometriosis, fibroids, HPV, heavy periods, ovarian cysts, ovarian cancer, PMS, uterine cancer or polyps, vulvar cancer **OR**: I have never had any female problems.