HUY N. DAO, D.O.

General and Advanced
Laparoscopic Surgery

HEALTH INFORMATION PRIVACY ACT

The office of Huy N. Dao, D.O. will provide the patients of this practice with what medical information they may request. The patients are said owners of there records along with Huy N. Dao, D.O. medical practice. You have the following rights to your health information.

You can inspect and request a copy of your health information at any time of being a patient of Huy N. Dao, D.O. medical practice. Request in writing will be granted. This practice has the right to charge for such transactions.

Your medical information at any time you feel there is incorrect information you may ask for that information to be corrected. These requests must always be in writing. The information changed must be of current knowledge of Doctor and patient. Please provide reason for such transaction in writing to the practice.

You as the patient have the right to allow certain persons of your family to be able to have knowledge of your medical condition. This request must also be in writing as to the persons allowed or persons with no access to your condition.

Your medical information will be shared with medical facilities with which we will schedule treatment, insurance company for which we will request medical authorizations.

Your medical information such as surgery, x-rays, labs, testing will also be shared with your primary doctor, for continuing care .

The employees of Huy N. Dao, D.O. General Surgery, are trained in the respect of our patients and vow to disclose no information of patients of this practice under the privacy act this practice has in place.

This notice will become effective September 1, 2007 and remain until the closure of said practice Huy N. Dao, D.O. General Surgery. This plan includes doctors, staff members, any associates of said practice.

This practice does have the right to change the plan as time goes on and more regulations are required.

The patient does have the right to change her or his mind as the plan does go on with the consent of information released as long as , the time is that the information has not been shared. This request will also require written notification.

Medical information will be shared with emergency facility for the benefit of the patient and proper treatment plan.

Medical information will be saved for a period of 7 years, if said patient has not been seen in that period of time the records can be destroyed. Minor's records have to be kept for a time till they reach the age of 18 yrs.

Please feel free to discuss any of these plans with Huy N. Dao, D.O. General Surgery at any time.

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Physician-Patient Arbitration Agreement

Article1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All claims Must be Arbitrated. It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any relate to treatment or services provided or not provided by the below indentified physician, medical group or association, their partners, associates, associations, patient, including any spouse or heir of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filling by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure 1280-1295 and the federal Arbitration Act (9 U.S.C 1-4). The parties shall bear their own costs, fees, and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: Retroactive Effect: The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefore and the remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By:_____
Physician's or Duty Date

By:_____
Print or Stamp Name of Physician
Medical Group or Association Name

By:_____
Signature of Translator (Date)
(if applicable)

By:_____
Patient's Signature Date

By:_____
Print Patient's Name

By:_____
Patient's Representative's Signature
(If applicable)

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OUR FINANCIAL POLICY

- Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment. All patients must complete our information and Insurance form before seeing the doctor.

- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
  ALL CO-PAYS, CO-INS AND DEDUCTIBLES MUST BE PAID AT TIME OF SERVICE.
  WE ACCEPT CASH, CHECKS, OR MAJOR CREDIT CARDS FOR YOUR CONVENIENCE.

- Regarding Indemnity Insurance
  We do accept assignment of insurance benefits on most Insurance Plans. **However, we do require that all Co-Pays, Co-Ins, and any Deductibles must be paid in full at time of service.** The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information, a copy of your insurance card and/or an original claim form. Your insurance policy is a contract between you and your insurance company. We are not a part to the contract.
  Regarding Insurance Plans where we are to participate as a provider, all co-pays, co-insurance and deductibles are due at time of treatment. In the event that your insurance coverage changes to a plan where we are not participating as a provider, refer to the above paragraph.

- **Minor Patients**
  The parents or guardians who accompany a minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied or re-scheduled unless charges have been pre-authorized to an approved credit plan or payment by cash or check at time of service.

- **Missed Appointments**
  Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $25.00 office visit. Please help us serve you better by keeping your scheduled appointments. If you are **10 minutes late** to your scheduled appointment, it will be rescheduled.

- **Interest**
  We reserve the right to charge interest in the amount of **15%** as provided by state law on all un-paid balances over 30 business days. We will bill a flat fee, however, of $25.00.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Signature of Co-Responsible Party Date

Huy N. Dao, D.O.

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:	Pharmacy Patient Uses:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]

❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ Welfare *(Please provide coupon)*	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Huy N. Dao, D.O.
General Surgery
1199 Delbon Ave Suite 5, Turlock, CA 95382
Telephone (209)656-0183 Fax (209)656-0199

Use and Disclosure of Medical Information

Acknowledgment, Notice of Privacy Practices

The Department of Health and Human Services establishes the HIPAA Privacy Rule to protect the privacy of identifiable health information. In accordance with this Rule, Huy N. Dao has prepared a Notice of Privacy Practices that is given to patients at their first visit.

Acknowledgment

I understand that Huy N. Dao. D.O May share my health information for treatment, billing, and healthcare operations. I have been given a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Huy N. Dao has the right to change this notice at any time, I may obtain a current copy by contacting the medical group's Privacy Official.

My Signature below constitutes my acknowledgment that I have been provided with a copy of the Notice of Privacy Practices.

Name (please print) Signature of Patient of Legal Representative Date

If signed by legal representative, relationship to patient: _____

Check here ☐ if patient refuses to sign. HND employee initials: _____

Disclosures to Family and Friends

With your permission, we may disclose your relevant health information to family members, friends, or other persons you identify below. This permission may be revoke by you at any time.

Name	Relationship	Phone Number

Signature:_____ **Date:**_____

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Patient Name:_____ Date:_____

Referral or Family Doctor: _____ Age: _____

- Why are you coming to see the doctor today?

_____

_____

_____

- How long have you had this problem? _____
- What Past or Current Medical conditions do you have? Check box (if applied) or fill in the blank

_____

_____

☐ Diabetes ☐ High Blood Pressure ☐ Seizures or Stroke ☐ Drug or Alcohol addiction

☐ Heart disease ☐ Kidney disease ☐ Lung disease ☐ Thyroid problems

☐ High Cholesterol ☐ Depression ☐ None of the above

Past surgeries:

_____

_____

Medication Allergies or Latex Allergies: _____ ☐ None

Current Medications: _____

_____

- Do you or did you smoke? If so, how many packs per day and for how many years?
- Do you drink alcohol? ☐ Yes ☐ No Drinks per day: _____Drinks per week:_____
- Recreational Drugs: ☐ No ☐ Yes
- Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow
- Type of Occupation:_____
- Family History: ☐ Diabetes ☐ High Blood Pressure ☐ Stroke or Heart Disease

☐ Cancer type: _____ ☐ None of the above

REVIEW OF SYSTEM FORM

(Please circle all that apply)

Patient Name:_____ Date:_____

Skin:	Rashes	Lumps	Sores	Moles	Itching	None
Head:	Headache	Dizziness	Light headaches			None
Eyes:	Visual changes	Glasses/contacts	Redness/discharge	Double vision	Eye pain	None
Throat:	Dental pain	Sore throat	Bleeding gums	Hoarseness	Voice changes	None
Neck:	Neck pain	Lumps	Swollen	Thyroid problems		None
Breasts:	Pain	Lumps	Discharge	Swollen nodes under arms		None
Lungs:	Cough	Difficulty breathing	Sputum production	Coughing up blood	Wheezing	None
Heart:	Hypertension	Fainting	Palpitations	Chest pain	Shortness of Breath walking	None
Intestinal:	Anorexia	Nausea	Vomiting	Black stool	Blood in stool	None
	Constipation	Diarrhea	Heartburns	Swallowing problems		
	Hemorrhoids	Hepatitis	Jaundice	Abdominal pain		
Urinary:	Frequent	Urgency	Painful Urination	Bloody or pink urine		None
	Incontinence	Flank pain	Hesitancy	Dribbling		
Male:	Penile discharge	Hernias	Testicular	Testicular masses	Sores	None
Female:	Menstrual problems	Vaginal discharge	Vaginal itching	Sores	Lumps / Hernias	None
Vascular:	Blood clots	Varicose Veins	Exertional leg pain	Leg cramps	Swollen ankles	None
Muscle:	Back Problems	Muscle problems	Stiffness	Joint problems	Recent Weight loss	None
Neuro:	Weakness	Stroke	Gait problems	Slurred speech		None
	Tremors	Seizures	Numbness	Tingling		
Blood:	Anemia	Bleeding	Easy bruisability	Prior transfusions		None
Lymp Nodes:	Swollen	Tender				None
Endocrine:	Diabetes	Thyroid disease	Heat or cold intolerance	Fever or chills		None
Psychiatric:	Depression	Nervousness	Anxiety	Mood	Thought disorder	None