# Sang H. Suh, M.D.

## REGISTRATION FORM

| Today's Date: | Referred to clinic by: |
|---|---|

**PATIENT INFORMATION**

| Patient's last name: | First name: | Marital status: |
|---|---|---|

| Is this your legal name? ◯ Yes ◯ No | If not, what is your legal name? | Birth date: | Age: | Sex: ◯ M ◯ F |
|---|---|---|---|---|

| Address: | City | State | Zip |
|---|---|---|---|

| Social Security no.: | Home phone no.: | Cell phone no.: |
|---|---|---|

Patent's Occupation/Employer:

**INSURANCE INFORMATION**

(Please give your insurance card to the receptionist.)

Please indicate primary insurance:

| Subscriber's name: | Subscriber's S.S. no.: | Birth date: | Group no.: | Policy no.: | Copayment: $ |
|---|---|---|---|---|---|

Patient's relationship to subscriber:

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

Patient's relationship to subscriber: Other:

**IN CASE OF EMERGENCY**

| Name of local friend or relative (not living at same address): | Relationship to patient: | Home 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

Sang H. Suh, M.D.

# MEDICAL RELEASE FORM

Today's Date:

**MY AUTHORIZATION**

I, ______________________________, hereby authorize Dr. Suh to RECEIVE, USE OR RELEASE specified confidential medical, psychiatric (including alcohol and/or drug) and/or educational information from the below indicated persons/agencies and for the stated reasons. I understand that this authorization extends to all or any part of the records/information.

**PERSONS/AGENCIES**

| Name: | Address: | Phone: |
|---|---|---|

Patient's relationship to subscriber:

Purpose: To aid in the success of treatment, to provide continuity of care

Information to Use or Release: Ability to talk with and release all healthy care information in my medical record

**PERSONS/AGENCIES**

| Name: | Address: | Phone: |
|---|---|---|

Patient's relationship to subscriber:

Purpose: To aid in the success of treatment, to provide continuity of care

Information to Use or Release: Ability to talk with and release all healthcare information in my medical record

**PERSONS/AGENCIES**

| Name: | Address: | Phone: |
|---|---|---|

Patient's relationship to subscriber:

Purpose: To aid in the success of treatment, to provide continuity of care

Information to Use or Release: Ability to talk with and release all healthcare information in my medical record

I understand, and I do not have to sign this authorization in order to get healthcare benefits. However, I do have to sign an authorization form to receive healthcare when the purpose is to create healthcare information for a third party.

I may revoke this authorization in writing. If it did, it would not affect any actions already taken by Dr. Suh based on upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Patient/Guardian signature                    Date

Sang H. Suh, M.D.

# ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND FINANCIAL AGREEMENT

(Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and RCW 70.02.120)

PMETS ("Covered Entity") keeps a record of the healthcare services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Privacy Officer, Santosh Agnoni, M.D. Written requests should be made to the Privacy Officer at the following address:

2820 Northup Way, Suit 105, Bellevue, WA 98004

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

## PATIENT ACKNOWLEDGMENT:

BY MY SIGNATURE BELOW I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES...

VERIFICATION OF MEDICAL CONSENT: l, the undersigned, hereby agree and consent to the plan of care proposed to me by the Covered Entity. I understand that l, or my authorized representative, have the right to decide whether to accept or refuse medical care. I will ask for any information I want to have about my medical care and will make my wishes known to the Covered Entity and/or its staff. The covered Entity shall not be liable for the acts or omissions of independent contractors.

AUTHORIZATION TO RELEASE INFORMATION: l, the undersigned, hereby authorize the Covered Entity and/or its staff, to the extent required to assure payment, to disclose any diagnosis and pertinent medical information to a designated person, corporation, governmental agency or third party payer which is liable to the Covered Entity for the Covered Entity's charges or who may be responsible for determining the necessity, appropriateness, or amount related to the Covered Entity's treatment or charges, including medical service companies, insurance companies, workmen's compensation carriers, Social Security Administration, intermediaries, and the State Department of Health and Human Services when the patient is a Medicaid or Medicare recipient. This consent shall expire upon final payment relative to my care.

## FINANCIAL AGREEMENT:

_______ (INITIAL) I DO NOT HAVE DSHS COVERAGE

PRIVATE PAY: l, the undersigned, hereby agree, whether signing as agent or as a patient, to be financially responsible to the Covered Entity for charges not paid by insurance. I understand this amount is due upon billing..

INSURANCE COVERAGE: J certify that the information given to me in applying for payment under government or private insurance is correct. I hereby assign payment directly to the Covered Entity for benefits otherwise payable to me. Any portion of charges not paid by the insurance company will be billed to me and is then due and payable within thirty (30) days of invoice. I understand the Covered Entity will verify my insurance coverage but that this does not guarantee payment by the insurance company and I will be responsible for all non-covered charges. I understand that it is my responsibility to determine the coverage limits of my insurance.

I understand a minimum monthly fee of 1% (annual rate of 12%) may be charged for late payment on all balances not covered by insurance. This is in addition to a charge for reasonable attorney fees, court costs, and collection agency expenses incurred to collect the amount due.

| ______________________________ | ______________________________ |
|---|---|
| Patient or legally authorized individual signature | Date |
| ______________________________ | ______________________________ |
| Printed name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative) |

Sang H. Suh, M.D.

# PATIENT DISCLOSURE

Welcome! We hope that you find the treatment you receive here efficient and effective.

Please take a moment to review the information below before receiving or before continuing to receive services. If you have any questions about these or any other topics, please ask our office staff for clarification.

## Our Practice:

Dr. Sang Suh provides psychiatric care to our patients by the way of psychiatric evaluation and ongoing medication management. We are psychiatrists but not counselors or therapist.

## Confidentiality:

All interaction between the patient and the psychiatrist are confidential. Please take a moment to review the HIPAA Compliance Notice of Privacy Practices that you have received from our office staff for a comprehensive explanation of our privacy policies.

## Emergencies:

During posted office hours, you may call Dr. Suh if you have a psychiatric emergency. The number is (425) 979-7850. However, you must call 911 or go to your nearest emergency facility, if Dr. Suh is delayed or unavailable for ANY reason.

## Laboratory Tests:

Lab tests may be required by Dr. Suh. These tests can be essential for the continued prescription of certain medications. Most insurance companies require orders for laboratory test that are validated by our primary care physicians and/or be conducted at designated labs. You will need to contact your insurance company for details when/if laboratory rests are required by Dr. Suh.

## Appointments:

Dr. Suh is capable of doing both in office appointments as well as virtual (telemedicine). Appointments are typically made by contacting Dr. Suh’s office staff. To ensure the highest quality of care and to monitor treatment plans as scientifically as possible, follow-up appointments should be made and kept as recommended by Dr. Suh.

If you have an immediate life-threatening emergency, call 911 rather than the office (since calling the office may result in an unforeseen delay). However, often problems that arise between sessions can and should be managed by scheduling an earlier appointment.

Scheduled appointment times are reserved especially for you. If an appointment is cancelled with less than 48 business hour notice, we reserve the right to charge $50 for that appointment. If an appointment is missed entirely, it will be considered a “No Show” and we reserve the right to charge $75 for that appointment. Repeated “Now Shows” and late cancels could result in discontinuation of further services.

## Reports/Letters:

Requests for letters or reports discussing your treatment or certain details of your treatment are not in the realm of our services. However, we understand that occasionally these requests are made. If you require a letter or report, we reserve the fight to charge a reasonable fee for that service.

## Insurance:

As a courtesy to you, we verify your benefits.

Please be aware that the insurance companies and managed care companies do not guarantee that the information they give us is correct. Therefore, we cannot guarantee this information either.

| ______________________________ | ______________________________ |
|---|---|
| Patient or legally authorized individual signature | Date |
| ______________________________ | ______________________________ |
| Printed name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative) |

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## ELECTRONIC PRESCRIPTION INFORMATION

Dr. Suh uses electronic prescriptions. Please provide the information for your pharmacy of choice. This will be considered your default pharmacy and all future prescriptions will be sent to this pharmacy. If you are in need of changing the pharmacies for whatever reasons, please contact the office to make this happen. Dr. Suh requests that most all prescription refill requests be made through your pharmacy and ask specifically that this be done in an electronic format. Faxes should be avoided due to inconsistencies and unreliability.

### Pharmacy:

Name: ________________________________________ Phone number: ________________________________

Address:___________________________________________________________________________________

City State Zip