HONGSHIK HAN, M.D., INC.
7005 N. Maple Ave., Suite 108
Fresno, CA 93720
(Located at the NW corner of Maple & Herndon Ave.)
Ph: (559) 325-3832 / Fax: (559) 325-2603

A Member of Santé Foundation Medical Group & Part of Santé Health Foundation

Dear Patient:

Welcome to Dr. Hongshik Han's office, and thank you for selecting our practice to care for your medical needs. Dr. Han is a Board Certified plastic surgeon specializing in hand surgery. He also has extensive experience in aesthetic, reconstructive, and microsurgery.

Please make note of the following:

1) You will need to complete all the enclosed forms in **black ink** and bring them with you to your appointment on _____ at _____.

2) **If your insurance company requires a referral or prior authorization for specialty care, it is your responsibility to be certain we have that referral prior to your appointment.** Your primary care physician will have to obtain the referral for Dr. Han.

3) **Bring your insurance card(s) and the name and address of your primary care doctor.** If you have a co-payment, please be prepared to pay that amount at the time of your visit. We accept checks, cash, or credit card. Patients will be charged a $35.00 fee for failure to notify our office 24 hours in advance if you cannot keep your appointment.

4) If you have had any x-rays, CT's, MRI's, or nerve conduction studies, please **hand carry your films** with you to your appointment in our office.

5) If you require Disability forms to be filled out, there will be a $30 fee for the preparation of these forms. The fee for FMLA forms is $20 and the fee for extension forms is $10.

Thank you for your attention to these matters. If you have any questions, please call our office at the above number. For more information about our office and the procedures Dr. Han performs, you may visit our website at **www.drhansurgery.com.**

Our office phone hours are Monday-Thursday 9:00 a.m.–5:00 pm (closed from noon to 2:00 pm), and Friday 9:00 am-12:00 Noon (except holidays).

Hongshik Han, M.D., Inc.

Board Certified Plastic & Reconstructive Surgeon

A MEMBER OF SANTÉ FOUNDATION MEDICAL GROUP & PART OF SANTÉ HEALTH FOUNDATION

Please print and complete all sections on all pages.

PATIENT'S PERSONAL INFORMATION

Patient's Name: _____
First Middle Last

Patient's Address: _____
Street City/State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient's SS#: _____ Patient's Birthday: _____ Age: _____

Patient's Sex: Male ☐ Female ☐ Patient's Occupation: _____

Patient's Employer: _____ Employer's Phone: _____

Emergency Contact Person: _____ Relation to Patient: _____

Emergency Contact's Phone #: _____ Emergency Contact's DOB: _____

Is the injury work-related? Yes ☐ No ☐

Date of Injury (if known): _____

Please specify area to be examined: _____

PATIENT'S INSURANCE INFORMATION

Primary Insurance Carrier: _____ Group #: _____ ID#: _____

Policyholder's Name: _____ Policyholder's SS#: _____

Policyholder's Date of Birth: _____

Secondary Insurance: _____ Group #: _____ ID#: _____

Policyholder's Name: _____ Policyholder's SS#: _____

Policyholder's Date of Birth: _____

Worker's Comp Insurance Name: _____ Claim #: _____

Worker's Comp Adjuster's Name: _____ W/C Adjuster's Phone # _____

PATIENT'S REFERRAL INFORMATION

Name of Primary Care Physician: _____

Primary Care Physician's Phone #: _____

Primary Care Physician's Address: _____
Street City/State Zip Code

Name of Referring Physician: _____ Date: _____ Phone #: _____

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Name: _____

Social History

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Exercise ☐ Daily ☐ Weekly ☐ Monthly ☐ Never

Smoking ☐ Yes (how much?) _____ ☐ Quit (how long ago?) _____ ☐ Never

Alcohol ☐ Yes (how much?) _____ ☐ Occasionally ☐ Never

Family History

Member	Alive	Deceased	Age/s
Father	☐	☐	_____
Mother	☐	☐	_____
Sister/s #____	#☐	#☐	_____
Brother/s #____	#☐	#☐	_____
Child(ren) #____	#☐	#☐	_____

Review of Systems

Are you currently having problems with any of the following?

	Yes	No	Describe all yes responses
Eyes	☐	☐	_____
Ears, Nose, Throat	☐	☐	_____
Heart	☐	☐	_____
Lungs, Breathing	☐	☐	_____
Bladder	☐	☐	_____
Bleeding	☐	☐	_____
Balance Problems	☐	☐	_____
Blackout/Fainting	☐	☐	_____
Numbness/Tingling	☐	☐	_____
Psychological Problems	☐	☐	_____
Weight Loss	☐	☐	_____
Fevers	☐	☐	_____
Osteoporosis	☐	☐	_____
Other	☐	☐	_____

Height: _____ Weight: _____ Race: _____ Primary Language: _____

Dominant Hand: ☐ Left ☐ Right

Preferred Pharmacy (Name and Phone #): _____

Patient Signature: _____ Date: _____

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Patient's Name: _____ Today's Date: _____

Allergies to Medications: _____

Please mark if you have had the following:

☐ High Blood Pressure ☐ Diabetes ☐ Ulcers ☐ Heart Arrhythmia ☐ Liver Disorder ☐ TB

☐ Coronary Artery Disease or Heart Attacks

☐ Seizures / Epilepsy

☐ Problems with Anesthesia

☐ Asthma

☐ Rheumatoid Arthritis

☐ Deep Vein Thrombosis

☐ Bleeding Disorder

☐ Emphysema of COPD

☐ Arthritis

☐ Polio

☐ Cancer (type): _____

☐ Other: _____

Surgeries / Hospitalizations Year Location

Medications

Please list ALL medications that you are currently taking.

Drug	Dose	Prescribing Doctor	Reason for medication

I acknowledge that I have read and completed the new patient registration and medical history forms fully, correctly, and to the best of my knowledge and the information I have given to Hongshik Han, M.D., Inc is complete and correct. I understand voluntarily or involuntarily withholding medical information can lead to complications or problems that may have been prevented if that information were known prior to my care.

Patient Signature: _____ Date: _____

Hongshik Han, M.D., Inc.

Cancellations / No Show Policy for Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment schedule.

If an appointment is not canceled at least 24 hours in advance, you will be charged a thirty-five dollar ($35) fee; this will not be covered by your insurance company. If you no show three (3) times, you will be discharged from the practice.

Patients who do not show up for surgery without a call to cancel at least 24 hours in advance are considered a No Show and will be subject to a $100.00 No Show Fee. This fee will not be submitted to insurance. Is is your responsibility and must be paid in full prior to rescheduling your surgery.

Your initials and signature constitute your acknowledgement that:

_____ You have read and agree to the above.

_____ _____

Patient/Guardian Signature Date & Time

_____

Relationship to patient

Hongshik Han, M.D., Inc.

Medical Records Privacy Policy

It is the policy of Hongshik Han, M.D., Inc. to maintain the privacy of the Medical Records we use. Our records consist of evaluations and recommendations as well as copies of laboratory studies, x-ray, and other studies, and consultations from other physicians. Some of the records are actually from the hospital and are included in the file. The Medical Record also includes letters to your referring physician and other consultants involved in your care. Finally, the record contains certain demographic information and your insurance information.

At Dr. Han's office, we are always concerned about the privacy of these records. It is our policy not to release any information from these records to others without your written permission. The only exceptions to this rule are records we send to your referring physician and consultants and the occasional request by your insurance company. If you are not aware, most insurance companies have you sign a Medical Information Release Form when you sign up with them.

We do not release information from the record unless you request and sign a release form. You have the right to specify which portion of the record we may release. Other than the exceptions mentioned above, Dr. Han will maintain a separate record of the date and information was sent and to whom it was sent. A nominal fee may be charged for the copying of the medical record.

If you have any questions about the Medical Record, feel free to ask our staff or Dr. Han.

Hongshik Han, M.D., Inc.

Signature: _____ Date: _____

(Patient or Guardian)

ASSIGNMENT OF INSURANCE BENEFITS & FINANCIAL POLICIES (Not applicable to workers' comp patients)

As a courtesy to our patients, we will bill your primary insurance carrier and secondary insurance, if applicable.

Hongshik Han, MD Inc. is a member of Santé Foundation Medical Group (SFMG) and you may receive a bill from SFMG for your services with our group.

I, as the patient / responsible party, hereby authorize payment for services rendered to be made directly to Santé Foundation Medical Group.

I understand that the balance on my account is DUE IN FULL, within 65 days of my appointment date and if my insurance carrier has not remitted payment within this time frame, I will pay the balance due. This also applies to any charges not covered or paid by my insurance carrier

Signature of Guarantor_____ Date_____

Relationship to Patient _____

FOR COSMETIC OR NO MEDICAL INSURANCE

If I do not have medical insurance or if I am being treated for cosmetic procedures, all surgical services will be prepaid and all office visits will be paid at the time services are rendered.

Signature of Guarantor_____ Date_____

Relationship to Patient _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, as the patient / responsible party, hereby authorize Hongshik Han, M.D. to release medical records, photos, or information pertaining to my treatment, which may be needed in the process of obtaining insurance pre-authorizations or may be needed for the purpose of billing my insurance carriers for several services rendered.

I also authorize release of any records to other physicians as needed to assist with medical needs.

Signature of Guarantor_____ Date_____

Relationship to Patient _____

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