Jason Song, M.D.

Song Heart & Vascular, P.C.

158-14 Northern Blvd. 2Fl. #UL-1 Flushing, NY 11358

Patient Demographic Form

Patient Name (Last, First, MI) (성함): ____

Date of Birth (생년월일): _____/ _____ / _______ **Gender (성별):** ☐Male ☐Female ☐Other

SSN#: ________ - _____ - ___________ **Email:** __________________________@__________________

Marital status (혼인여부): ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Race: ☐Asian ☐American Indian/Alaskan Native ☐Black/African American
☐Native Hawaiian/Pacific Islander ☐White ☐Other ☐Unknown

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino

Home Address (집주소): ____

Home Phone: (   ) _________ - ___________ **Cell Phone:** (   ) _________ - ___________

Emergency contact: (   ) ________ - ___________ **Relationship to patient (환자와의 관계):**

PCP's Name (주치의 성함): ___________________________ / **Pharmacy (약국):** ___________________

INSURANCE INFORMATION

Primary Insurance Company: ____

Insurance ID#: ______________________________________ **Group#:** ___________________________

Patient's Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other

Name of Subscriber: ______________________________ **Date of Birth:** _____/ _____ / _________
(If other than patient)

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature: X______________________________ **Signed Date:** _____/ _____ / __________

Guarantor Signature: ______________________________ **Signed Date:** _____/ _____ / __________
(If other than patient)

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HIPAA COMPLIANCE PATIENT CONSENT FORM

Our notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's right section describing your rights under the law. You ascertain that by your signature you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature and date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing. signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment. payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

___

This consent was signed by: ________________________________ **Date:** ____/ ____ / _______

(PRINT NAME PLEASE)

Signature: X____ **Date:** ____/ ____ / _______

Witness: ____ **Date:** ____/ ____ / _______