Beauty Swe, M.D.
301 South Fair Oaks Avenue, Suite 203
Pasadena, CA 91105

Tel: (626) 356-4000
Fax: (626) 799-4001

REGISTRATION FORM

PATIENT INFORMATION

Last name:	**First:**	**Middle:**	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Marital status (circle one)** Single / Mar / Div / Sep / Wid
SSN:	**Driver's License:**	**Birth Date:** / /	**Sex:** ❑ M ❑ F		
Street address:		**City:**	**State:**	**Zip Code:**	
Home phone #: ( )	**Cell phone #: ( )**		**Work phone #: ( )**		
Email:					
Race: ❑ American Indian/Alaska Native ❑ Asian ❑ African American ❑ Hawaiian/Pacific Islander ❑ Hispanic or Latino ❑ White ❑ Other: _____					
Preferred Language:	**Occupation:**	**Employer:**			
Pharmacy:	**Phone no.: ( )**	**Fax no.: ( )**			
Chose office because/Referred to office by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital		
❑ Family	❑ Friend	❑ Close to home/work	❑ Other		

SPOUSE OR PARENT INFORMATION

Last name:	**First:**	**Relationship to patient:**	**Home phone no.:** ( )	**Work phone no.:** ( )

INSURANCE INFORMATION

Are you the Subscriber? ❑ Yes ❑ No	**If No, Subscriber's Name:**			
Subscriber's SS#:	**Subscriber's Birth date:** / /	**Subscriber's Address (if different):**		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other
Name of secondary insurance (if applicable):	**Subscriber's name:**	**Member ID no.:**	**Group no.:**	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	**Relationship to patient:**	**Home phone #:** ( )	**Cell phone #:** ( )

Financial Agreement: I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I must pay all cost of collection, and attorney's fee. If I have provided a cell phone number, I acknowledge that I may be contacted at that number for account servicing matters, including but not limited to collecting on my account.

Assignment of Benefits: I hereby give lifetime authorization of payment to be made directly to Beauty Swe, M.D. and any assisting physicians, for services rendered. I hereby authorize this Health Care Provider to release all information necessary to secure payment of benefits.

Consent for Healthcare and Release of Medical Information: I voluntarily consent to healthcare treatment from Beauty Swe, M.D., staff and any assisting physicians. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of treatments or examinations. I consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations. I have read this form. I have had the opportunity to ask questions and my questions have been answered.

_____ _____

Patient/Guardian signature ***Date***

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Preferred Method for Receiving Confidential Information

I wish to be contacted in the following manner (Check all that apply):

❑ Home Telephone: _____
- ❑ OK to leave message with detailed information
- ❑ Leave message with call-back # only

❑ Work Telephone: _____
- ❑ OK to leave message with detailed information
- ❑ Leave message with call-back # only

❑ Cell phone: _____
- ❑ OK to leave message with detailed information
- ❑ Leave message with call-back # only

❑ Email: _____

❑ Written Communication:
- ❑ OK to mail to my home address
- ❑ OK to mail to work address: _____
- ❑ OK to fax to this number: _____

Patient/Guardian's Signature: _____ Date: _____

Print Name: _____

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INSURANCE ELIGIBILITY WAIVER

It is imperative that you **confirm and update your insurance** with us before each office visit with your doctor. It is ultimately your responsibility to know which providers and services are covered by your insurance. Billing your insurance is a service we offer to our patients.
Co-payments are due and collected at the time of each office visit. They are a part of your insurance contract and we are REQUIRED to collect them. These payments are posted to your account by our billing service.

BILLING
We need to know your current insurance carrier so we can meet their deadlines for billing services. If you have changed insurance plans and not informed us, we will bill the information we have on file. If the claim is denied, we will bill you directly for payment. You must then seek reimbursement from your current insurance carrier. Our biller requires your Social Security Number for billing purposes only. If you decline to provide your number, please be advised that you may be billed for the services rendered by the doctor.

REFERRALS
If you need to be referred for services outside our office, your doctor will try to direct you to a provider contracted with your insurance. Current information is vital to this task. Otherwise, you may be referred to a non-contracted provider. You will be responsible for payment. We are not responsible for non-covered services or for the cost of services provided by a non-contracted provider.

MISSED APPOINTMENTS
Unless cancelled or rescheduled 24-hours in advance, our policy is to charge $25 for missed and late cancelled/rescheduled appointments. Insurance plans will not pay for this charge so please help us serve you better by keeping scheduled appointments.

WAIVER

I understand that if I am not eligible for insurance benefits for todayôs visit, I will be financially responsible for the services performed by the doctor. I understand that if my insurance requires me to choose a primary care physician (PCP) and Dr. Beauty Swe is not my PCP, I will be held financially responsible for the services performed. In the event of default, I must pay all cost of collection, and attorneyôs fee. If I have provided a cell phone number, I acknowledge that I may be contacted at that number for account servicing matters, including but not limited to collecting on my account.

Patien/Guardian's Signature: _____ Date: _____

Print Name: _____ Social Security #: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received your ***Notice of Privacy Practices***. I understand that Beauty Swe. M.D., Inc. has a right to change its ***Notice of Privacy Practices*** from time to time and that I may contact Beauty Swe, M.D., Inc. at any time at the address above to obtain a current copy of the ***Notice of Privacy Practices***.

Patient's Name: _____

Patient's Personal Representative & Relationship: _____

Signature: _____ Date: _____

OFFICE USE ONLY

I have made a good faith effort to obtain a written acknowledgement of receipt of the ***Notice of Privacy Practices*** from the above named patient, but was unable to for the following reason:

❑ Language barrier

❑ Patient cannot read

❑ Patient objects

❑ Read later and return

❑ Unable to sign

❑ Other: _____

Employee Name: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

***This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions, please contact our Privacy officer at the address or phone number at the bottom of this notice.*Who will follow this notice?**

Beauty Swe, M.D., Inc. provides healthcare to our patients in partnership with other professionals and healthcare organizations. The information privacy practices in this notice will be followed by any healthcare professional who treats you at our location.

While each of these facilities and affiliates operate independently, they may share your health information for coordination of care, treatment, payment and healthcare operations purposes.

Our pledge to you:

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care generated by any of the separate facilities and providers. We are required by law to:

- Keep medical information about you private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

How we may use and disclose medical information about you:

We may use and disclose medical information about you without your prior authorization for treatment (such as sending medical information about you to a specialist as part of a referral) (this includes psychiatric or HIV information if needed for purposes of your diagnosis and treatment); to obtain payment for treatment (such as sending billing information to your insurance company or Medicare); and to support our healthcare operations (such as comparing patient data to improve treatment methods or for professional education purposes) (Note: only limited psychiatric or HIV information may be disclosed for billing purposes without your authorization). If you are treated in a specialized substance abuse program, your special authorization will be needed for most disclosures other than emergencies.)

Other examples of such uses and disclosures include contacting you for appointment reminders and telling you about or recommending possible treatment options, alternatives, health-related benefits or services that may be of interest to you. We may also contact you to support our fundraising efforts.

We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give our medical information about you, without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, medical examiners, funeral arrangements and organ donation, workers' compensation purposes, emergencies, national security and other specialized government functions, and for members of the Armed Forces as required by Military Command authorities. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders or other legal process.

Under certain circumstances, we may use and disclose health information about your for research purposes, subject to special approval process. We may allow potential researchers to review information that may help them prepare for research, so long as the health information they review does not leave our facility, and so long as they agree to specific privacy protections.

We may use and disclose medical information about you without your prior authorization to a Business Associate as part of contracted agreement to perform services for the medical group.

If you are involved in a lawsuit or a dispute, we may disclose medical information about you, without your prior authorization, in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena without your prior authorization.

We may disclose medical information about you to a friend or family member whom you designate or in appropriate circumstances, unless you request a restriction. We may also disclose information to disaster relief authorities so that your family can be notified of your location and condition.

Other uses of Medical Information:

In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us In writing of your decision.

Right to Access and Amend Your Records:

In most cases, you have the right to look at or get a copy of medical information that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing, or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision. You may request a clinical summary of your visit at the end of each visit.

If you believe that information in your record is incorrect or that important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information is not maintained by us, or if we determine that your record is accurate. You may submit a written statement of disagreement with a decision by us not to amend a record.

Right to an Accounting:

You have the right to request a list of accounting for any disclosure of your health information we have made, except for uses and disclosures for treatment, payment, and healthcare operations, circumstances in which you have specifically authorized such disclosure, and certain other exceptions.

To request this list of disclosures, indicate the relevant period which must be after April 14, 2003, but in no event for more than the last six years. You must submit your request in writing to the Privacy Officer listed below.

Right to Request Restrictions:

You may request, in writing, that we not use or disclose medical information, about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request and work to accommodate it when possible, but we are not legally required to accept it. We will inform you of our decision on your request.

All written requests or appeals should be submitted to the Privacy Officer listed below.

Requests for Confidential Communications:

You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

Right to request a paper copy of this Notice:

You may receive a paper copy of this Notice from us upon request, even if you have agreed to receive this notice electronically.

Changes to this Notice:

We may change our policies at any time, Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice in the lobby. You can receive a copy of the current notice at any time. The effective date is listed at the end. Copies of the current notice will be available each time you come to our office for treatment. You will be asked to acknowledge in writing your receipt of this notice.

Complaints:

If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact the Privacy Officer listed below.

If you are not satisfied with our response, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Office can provide you the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Effective Date: June 21, 2011

Privacy Officer: Beauty Swe, M.D.