Haoxu Ouyang Medical PLLC
132-27 41st Rd #2C, Flushing, NY 11355
WEBSITE: www.drouyangcare.com
EMAIL: contact@drouyangcare.com
TEL: 718-269-5055
FAX: 516-706-3880

Patient Registration Form (患者登记表)

Please complete all applicable sections. If an item does not apply, leave it blank. (请完成所有相关章节。如某项不适用，请留空。)

Basic Information (基本信息)

First Name (名) | Middle Name (中间名) | Last Name (姓) | Date of Birth (生日) MM/DD/YYYY

Sex at Birth (出生性别) | Gender Identity (性别认同) | Race (种族) | Ethnicity (民族)

Marital Status (婚姻状况) ☐ Single (单身) ☐ Married (已婚) ☐ Other (其他) _____

Contact Information (联系信息)

Street Address (住址) | City (城市) | State (州) | ZIP Code (邮政编码)

Phone Number (电话) | Alternate Phone (备用电话，如有) | Email Address (邮箱)

Emergency Contact (紧急联系人) | Relationship (关系) | Emergency Contact Phone (紧急联系人电话)

Medical Information (医疗信息)

Primary Insurance Company (主要保险公司) | Insurance ID / Policy No. (保险号) | Group Number (组号)

If applicable: (如适用)

Secondary Insurance Company (第二保险公司) | Insurance ID / Policy No. (保险号) | Group Number (组号)

Pharmacy Name (药房名称) | Pharmacy Phone (药房电话)

Pharmacy Address (药房地址) | City (城市) | State (州) | ZIP Code (邮政编码)

If policy holder is not the patient: (若保险持有人不是病人本人)

Holder's First Name (保险持有人名) | Holder's Middle Name (保险持有人中间名) | Holder's Last Name (保险持有人姓)

Holder's Relation (保险持有人与本人关系) | Holder's Gender (保险持有人性别) | Holder's Date of Birth (保险持有人出生日期)

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Declarations & Consents (声明与同意书)

1. Privacy Notice & Patient Acknowledgement (隐私通知与患者确认)

I hereby confirm that the information on the previous page of this form I have provided is true and accurate to the best of my knowledge. And I understand the information is Protected Health Information (PHI). I acknowledge that I have received or been offered the clinic's Notice of Privacy Practices (NPP), which explains how my health information may be used and disclosed.
（我确认我在本表前一页所提供的信息据我所知真实且准确，并了解该信息属于受保护的健康信息 (PHI)。我确认我已经收到或诊所已向我提供《隐私惯例通知》(NPP)，其中说明我的健康信息将如何被使用和披露。）

2. Assignment of Benefits & Financial Responsibility (理赔授权与财务责任)

I authorize my insurance benefits to be paid directly to Haoxu Ouyang Medical PLLC and authorize release of medical or other information necessary to process claims. I understand I am financially responsible for non-covered services, co-payments, and deductibles.
（我授权保险理赔金直接支付给 Haoxu Ouyang Medical PLLC，并授权诊所发布处理保险索赔所需的医疗或其他信息。我了解并同意，我对保险未承保服务、共付额和免赔额负有经济责任。）

3. SMS Communication Consent (短信沟通同意)

I consent to receive SMS messages from Haoxu Ouyang Medical PLLC for appointment reminders, rescheduling, and other healthcare-related communications. I understand standard messaging rates may apply and that the clinic will protect my health information in accordance with HIPAA.
（我同意 Haoxu Ouyang Medical PLLC 通过短信向我发送预约提醒、改期通知及其他医疗相关信息。我了解可能产生标准短信费用，诊所将依照 HIPAA 保护我的健康信息。）

4. Telehealth Visit and Insurance Billing Consent (远程医疗与保险计费同意)

I understand that a telehealth visit is considered a virtual office visit and may be billed to my insurance in the same manner as an in-person office visit. I have had the opportunity to ask questions and understand the billing information provided.
（我了解远程医疗就诊属于线上诊室就诊，可按线下诊室就诊方式向我的保险计费。我已有机会询问相关问题，并理解诊所提供的计费说明。）

5. Insurance Coverage & Lab Billing Notice (保险覆盖与实验室账单告知)

I understand that deductibles and out-of-pocket costs may apply. Medically necessary lab tests ordered during a visit, including an annual preventive visit, may not be considered preventive by my insurance and may not be fully covered. Lab billing is separate from office billing, and any remaining balance may be billed directly by the laboratory.
（我了解若保险计划有免赔额或自付责任，我可能需要承担相关费用。医生根据病情开具的必要化验，即使在年度预防性体检中进行，也可能不被保险认定为预防项目，且可能无法全额承保。实验室账单与诊所账单分开，余额可能由实验室直接向我收取。）

By signing below, I acknowledge and agree to all declarations, consents, authorizations, and notices listed above.
（通过下方签名，我确认并同意以上所有声明、同意、授权与告知内容。）

Patient Signature (患者签字)	Print Name (正楷姓名)	Date (日期)

Electronic signature or handwritten signature required. (需电子签名或手写签名)