Haoxu Ouyang MEDICAL PLLC

Haoxu Ouyang Medical PLLC
132-27 41st Rd #2C
Flushing, NY 11355

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Patient Registration Form (患者登记表)

Please complete all applicable sections. If an item does not apply, leave it blank.

Basic Information (基本信息)

Full Name (姓名) _____ Date of Birth (生日 MM/DD/YYYY) _____ Sex / Gender (性别) _____

Marital Status (婚姻状况) ☐ Single (单身) ☐ Married (已婚) ☐ Other (其他) _____ ☐ Prefer not to say (不愿透露)

Race (Optional) (种族，可选) _____ Ethnicity (Optional) (民族，可选) _____

Contact Information (联系信息)

Phone Number (电话) _____ Email Address (邮箱) _____

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

Emergency Contact (紧急联系人) _____ Relationship (关系) _____ Phone Number (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) _____

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)

Policy Holder Name (保险持有人姓名) _____ Relationship to Patient (与本人关系) _____

Policy Holder DOB (保险持有人生日) _____ Policy Holder Sex (保险持有人性别) _____

Declarations & Consents (声明与同意书)

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

I hereby authorize my insurance benefits to be paid directly to Haoxu Ouyang Medical PLLC. I authorize the release of any medical or other information necessary to process insurance claims on my behalf. I understand that I am financially responsible for all non-covered services, co-payments, and deductibles.
(我特此授权我的保险理赔金直接支付给 Haoxu Ouyang Medical PLLC。我授权诊所代表我发布处理保险索赔所需的任何医疗或其他信息。我了解并同意，我对所有保险未承保的服务、共付额（Copay）和免赔额（Deductible）负有经济责任。)

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

The information provided on this form is considered Protected Health Information (PHI). Our clinic strictly adheres to HIPAA regulations regarding the privacy and security of your PHI. By signing below, I certify that the information I have provided is accurate to the best of my knowledge. I also acknowledge that I have received or been offered a copy of the clinic's Notice of Privacy Practices (NPP), which details how my health information may be used and disclosed.
(本表单提供的信息属于受保护的健康信息 (PHI)。本诊所严格遵守 HIPAA 法规，保障您的隐私与信息安全。通过下方签名/勾选，我证明我所提供的信息准确无误，我也确认我已经收到或诊所已向我提供了《隐私惯例通知》(NPP) 的副本，其中详细说明了我的健康信息将如何被使用和披露。)

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)

Staff Use Only (仅工作人员填写)

Staff Signature (工作人员签名) _____ Date (日期) _____ Other Notes (其他备注) _____