

Tehming Liang, M.D.,PhD.

OFFICE POLICIES

1. WE REQUIRE A 24-HOUR NOTICE WHEN CANCELLING OR RESCHEDULING AN APPOINTMENT.
2. WE ACCEPT MOST MAJOR INSURANCE CARRIERS.
3. CO-PAYS ARE DUE UPON ARRIVAL AND REQUIRED FOR EVERY VISIT EXCEPT CERTAIN PROCEDURES.
4. IF YOU ARE A **SELF-PAYING PATIENT**, PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, VISA, MASTER CARD, DISCOVER CARD AND DEBIT CARDS. SORRY NO PERSONAL CHECKS.
5. THE PARENT OR GUARDIAN OF A MINOR IS RESPONSIBLE FOR ANY INCURRED CHARGES.
6. IF YOUR INSURANCE REQUIRES A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN TO SEE A SPECIALIST, THE PATIENT IS RESPONSIBLE FOR KEEPING THE REFERRAL CURRENT. WE ARE UNABLE TO OBTAIN A REFERRAL FOR YOU. WITH YOUR COOPERATION, YOU SHOULD BE ABLE TO RECEIVE ALL THE BENEFITS OFFERED TO YOU, AND WE WILL BE ABLE TO CONCENTRATE ON CARE FOR YOUR MEDICAL NEEDS.
7. WE WILL BILL YOUR **PRIMARY** INSURANCE COMPANY FOR ALL NON-COSMETIC PROCEDURES. YOU ARE RESPONSIBLE FOR ANY BALANCE AND PAYMENT IS DUE UPON RECEIPT OF A STATEMENT FROM OUR OFFICE.
8. IF YOUR INSURANCE COMPANY REQUIRES A SOCIAL SECURITY NUMBER AND YOU DO NOT FURNISH IT, YOU WILL BE RESPONSIBLE FOR THE PAYMENT.
9. IT IS YOUR RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES, I.E. INSURANCE, PHONE OR ADDRESS.

PLEASE INITIAL AND DATE UPON RECEIPT _____

DATE _____

Tehming Liang, M.D., Ph.D.

DIPLOMATE, AMERICAN BOARD OF DERMATOLOGY

PATIENT CONSENTS FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that, under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights to privacy regarding my medical information. I understand that this information can and will be used for the following:

1. Treatment: My medical information may be used by staff members or disclosed to other health care professionals for the purpose of treatment.
2. Payment: My medical information may be used to seek payment from my health insurance plan.
3. Healthcare operations: My information may be used to conduct business practice such as quality assessment and cost-management.
4. Appointment reminders: With my consent, Dr. Liang or a staff member may call my home or other designated location and leave a message on voice mail or to a family member or by mail regarding my clinical care, such as appointment reminders and laboratory results as appropriate.

I may request a copy of the "Notice of Privacy Practices" which fully describes the uses and disclosures of my health information for treatment, payment and healthcare operations.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, and healthcare operations. I also understand that you are not required to agree to my requested restrictions. But if you do agree, then you are bound to abide by such restrictions.

Signature of Patient or Legal Guardian

Print Name of Guardian

Print Patient's Name

Date

NEW PATIENT REGISTRATION

Tehming Liang, M.D.,Ph.D.
Dermatology

580 E. Boughton Road, Suite A
Bolingbrook, IL 60440

Date ____ / ____ / ____
M D Y

Patient's Name _____ Birth Date ____ / ____ / ____ Sex: M F
Last First Middle Initial M D Y Circle

Address _____
Street City State Zip

Social Security No. ____ - ____ - ____ Phone: (____) ____ (____) ____
home cell

Occupation _____ Employer _____ Work Phone (____) ____

Employer's Address _____

Marital Status: ____ Married ____ Divorced ____ Separated ____ Single ____ Widowed

Spouse's Name _____ Birth Date ____ / ____ / ____

Social Security No. ____ - ____ - ____ Occupation _____

Employer _____ Work Phone (____) ____

Employer's Address _____
Street City State Zip

Policy Holder _____ Birth Date ____ / ____ / ____
Last First Middle Initial

Address (if different) _____

Home Phone (____) ____ S. S. No. ____ - ____ - ____ Relationship _____

Insurance Co. _____ Group/Plan No. _____

Primary Care Physician _____ Phone (____) ____

Address _____
Street City State Zip

Referred By: ____ Physician ____ Friend & Family ____ Medical Society & Hospital ____ Phone Book ____ Insurance
____ Sign Outside ____ Internet ____ Others _____

- I authorized the following:**
- (1) Treatment for the patient named above and responsibility for the charges incurred in the office and for hospitalization regardless of insurance claims.
 - (2) Release of these medical records to the requesting insurance company.
 - (3) Direct payment of my Medicare, PPO, or HMO to the participating physician for service rendered.

Signature of Responsible Person _____

Medical History Information

Tehming Liang, M.D., Ph.D
Dermatology

Name: _____ Date _____

What is the reason for your visit and how long you have had this problem?

What treatments have you tried for this problem ?

What other medical problems do you currently have ?

What medical problems or surgeries have you had in the past?

Medicines you are currently taking:

Have you ever had an allergic reaction to any medication? ____ Yes ____ No

If so, please give the name of the medication and describe what happened:
