ANDREA TIENG, MD
GASTROENTEROLOGY & HEPATOLOGY
Upland | Rancho Cucamonga | Redlands | San Bernardino

Andrea Tieng, MD
10801 Foothill Boulevard, Suite 106
Rancho Cucamonga, CA 91730

Phone: (909) 255-7200
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andreatiengmd@gmail.com

ANDREA TIENG M.D. INC

DATE: _____

ACCOUNT #	PATIENT LAST NAME	FIRST NAME	M.I.
(OFFICE USE ONLY)			

STREET ADDRESS	APT #	CITY/STATE	ZIP CODE

SEX	BIRTHDATE	AGE	SOCIAL SECURITY #	HOME TELEPHONE #	CELL PHONE #

PRIMARY CARE PHYSICIAN'S FULL NAME	OFFICE TELEPHONE #

REFERRED BY	TELEPHONE #

PREFERRED PHARMACY

NAME:	TELEPHONE:

EMERGENCY NOTIFICATION

NAME:	RELATIONSHIP:	TELEPHONE:	
STREET ADDRESS:	APT #:	CITY/STATE:	ZIP CODE:

EMPLOYMENT INFORMATION

EMPLOYEER NAME:	WORK TELEPHONE:	
STREET ADDRESS:	CITY/STATE:	ZIP CODE:
OCCUPATION:		

INSURANCE COMPANY (PRIMARY)

NAME:		MEMBER ID or MEDICARE ID:			
INSURANCE COMPANY ADDRESS:		CITY/STATE:			ZIP CODE:
GROUP NUMBER:	SUBSCRIBER'S NAME (if not patient) AND DATE OF BIRTH:	MM	DD	YY	RELATION:

INSURANCE COMPANY (SECONDARY)

NAME:		MEMBER ID or MEDICARE ID:			
INSURANCE COMPANY ADDRESS:		CITY/STATE:			ZIP CODE:
GROUP NUMBER:	SUBSCRIBER'S NAME (if not patient) AND DATE OF BIRTH:	MM	DD	YY	RELATION:

THIRD PARTY BILLING (OR REMARKS)

THIRD PARTY NAME:			
STREET ADDRESS:	APT NO:	CITY/STATE:	ZIP CODE:

AUTHORIZATION TO PAY

I, _____ HEREBY AUTHORIZE _____ TO PAY DIRECTLY TO ANDREA S. TIENG, M.D. THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE FOR HIS/HER SERVICES AS DESCRIBED BY MY INSURANCE FORM HEREOF, BUT NOT TO EXCEED THE CHARGES FOR THOSE SERVICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THOSE CHARGES NOT PAID BY MY INSURANCE COMPANY.

DATE: _____ SIGNATURE: _____

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Name: _____ **Date:** _____

Reason for visit (ie, symptoms):

_____

Do you have any medical problems? (ie, diabetes, high blood pressure, etc...)

_____

_____

_____

_____

Have you had any surgeries, including colonoscopy and upper endoscopy, in the past? If yes, when?

_____

_____

_____

_____

What medications are you currently taking?

_____

_____

_____

_____

Please list any allergies to medication: _____ ☐ No allergies

Do you smoke? ☐ No ☐ Yes How much and how often?

Do you drink? ☐ No ☐ Yes How much and how often?

Is there a family history of colon cancer? ☐ No ☐ Yes If yes, who and what age were they diagnosed?

_____

_____

_____

_____

Is there anything else you would like us to know about?

_____

_____

_____

_____

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Patient Record of Disclosures

In general, the HIPPA policy rule gives the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

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 number only

Work telephone: _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

Written communication: _____

- ☐ OK to mail to my home address
- ☐ OK to mail to my work/office address
- ☐ OK to fax to this number:

If you would like to give our office permission to discuss your protected health information and your account/billing information with your spouse or any other individual, please list the names of those individuals here:

_____

_____

_____

Other instructions:

_____

_____

_____

Patient signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

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NOTICE OF PRIVACY PRACTICES

This practice is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of your Health Care Information

1. We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations.
2. We may disclose your health information to your insurance provider for the purpose of payment or health care operations.
3. We may disclose your health information as necessary to comply with State Workers' Compensation Laws.
4. We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.
5. As required by law, we may disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and r reactions to medications, and reporting disease or infection exposure.
6. We may disclose your health information in the course of any administrative or judicial proceeding.
7. We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.
8. We may disclose your health information to coroners or medical examiners.
9. We may disclose your health information to organizations involved in procuring, banking, or transplanting organs or tissues.
10. We may disclose your health information to researchers conducting research that has been approved by an Institutional Reveal Board.
11. It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.
12. We may disclose your health information for military, national security, prisoner and government benefits purposes.
13. We may contact you for the purpose of making an appointment or to remind you of an existing appointment. If you are not at home, we may leave a reminder message on your answering machine or voice mail or with a person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment or a request to call us so that an appointment can be made.
14. In the event that this practice is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

1. You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that this practice is not required to agree to the restriction that your requested.
2. You have the right to have your health information received or communicated through an alternate method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
3. You have the right to inspect and copy your health information.
4. You have a right to request that this practice amend your protected health information. Please be advised, however, that this practice is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
5. You have the right to receive an accounting of disclosures of your protected health information made by this practice.
6. You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

This practice reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, this practice is required by law to comply with this Notice.

This practice is required by law to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact our Privacy Officer by calling this office.

Complaints

Complaints about your privacy rights, or how this practice has handled your health information should be directed to our Privacy Officer by calling this office.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights, 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201

This Notice is effective as of the date shown below. I have read this Privacy Notice and understand my rights contained in this notice. By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in this Privacy Notice.

_____
Patient's Name

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date