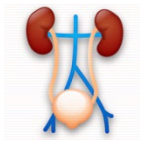

Welcome to Our Office

James T. Song, M.D. & **Kenneth R. Woo, M.D.**

2007 Rock Spring Road
Forest Hill, MD 21050

464 Alliance Street
Havre de Grace, MD 21078

PATIENT INFORMATION

Name:_____
(Last) (First) (Middle Initial)

Address:_____
(Street) (City) (State) (Zip)

Primary Phone #:_____ Work Phone #:_____

Cell Phone #:_____ Birth Date:_____ /_____ /_____ S.S #:_____-_____-_____
(Month) (Day) (Year)

Sex: F / M Race:_____ Preferred Language:_____
(Required by MD Dept of Health)

Email Address:_____ Marital Status:_____

Emergency Contact:_____ /_____ Phone #:_____
(Relationship to patient)

Primary Care/Referring Physician:_____ Phone#:_____

PATIENT EMPLOYMENT

Employment Status:
(Please Circle) FULL TIME PART TIME SELF EMPLOYED RETIRED OTHER:_____

INSURANCE INFORMATION

Please list insurance through your employer as the primary insurance company.

PRIMARY INSURANCE COMPANY:_____

Policy Holder's Name: _____ /_____
(Relationship to patient)
Insurance Policy #:_____ Group#:_____

Policy Holder's Date of Birth:_____ Specialist copay amount:_____

SECONDARY INSURANCE COMPANY:_____

Policy Holder's Name: _____ /_____
(Relationship to patient)
Insurance Policy #:_____ Group#:_____

Policy Holder's Date of Birth:_____ Specialist copay amount:_____

FINANCIAL POLICY FOR HARNE, SONG, & WOO, M.D., P.A.

Thank you for choosing us as your health care provider. We are committed to your health and successful treatment. Please understand that payment of your bill is very important, as it allows us to continue providing you with the highest and most caring level of service. The following is a statement of our Financial Policy, which we require that you read and sign prior to your treatment.

- **It is your responsibility to supply this office with your current address, a copy of your insurance card, and other forms of ID. Also, a referral from your primary care doctor if necessary.**
- **If any of the above information changes, YOU must notify us immediately.**
- **If you have insurance with whom we participate, we will submit the claim for you. You will be responsible for payment of any copayments, coinsurance, or deductibles at the time services are rendered. We cannot guarantee your eligibility or benefits. However, we will work with you and your insurance company to help you understand your policy, its limitations, and your financial responsibility.**
- **Once your primary insurance has paid the claim, if you have secondary insurance, we may elect to bill them the full balance due on your account. If your secondary insurance does not pay within 30 days, we will expect you to pay the balance of your bill upon request.**
- **If you have no insurance or elect to self-pay your account, payment is due at the time service is rendered, unless other arrangements are made in advance with the insurance/billing staff.**
- **We offer several payment methods, including: check, cash, and credit cards. Full payment is expected within 90 days, unless there are extenuating circumstances. Returned check fee is $25.00.**
- **If you are having difficulty paying, it is your responsibility to work out a flexible payment schedule with our billing staff. We are always willing to help you, and remain responsive to your financial needs. Our goal is to help you meet your financial responsibilities, without causing you financial hardship.**
- **If you have any questions or concerns regarding our billing policy, please do not hesitate to ask our billing staff. Remember, the Doctor concentrates only on your medical needs. The billing staff will discuss your financial arrangements.**

I hereby certify that I (or my dependent) assign directly to Harne, Song, & Woo, M.D., P.A., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges not paid by my insurance company.

I authorize any physician, hospital, insurance company, employer, or organization to release the information necessary to secure treatment or payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of Patient or Guarantor: **Date:**

Harne, Song & Woo, MD, PA
Caring Adult and Pediatric Urology
Since 1982

JAMES T. SONG, M.D. **KENNETH R. WOO, M.D.** **SARON BELAY, PA-C**

2007 ROCK SPRING ROAD
FOREST HILL, MD 21050
(410)879-4879 (410)838-7232
FAX (410)893-4763

BEL AIR AMBULATORY SURGICAL CENTER, L.L.C.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT:

You may request a Notice of Privacy Practices of Harne, Song, & Woo, M.D. P.A/Bel Air Ambulatory Surgical Center, L.L.C. Harne, Song, & Woo, M.D. P.A./ Bel Air Ambulatory Surgical Center, L.L.C. are authorized to use and disclose health information for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

By signing this form you are complying to HIPAA. I authorize and request Harne, Song, & Woo, M.D. P.A./ Bel Air Ambulatory Surgical Center, L.L.C. to disclose my protected health information to the party or parties listed below. The request includes general health information, lab, & operative results, and billing information. This is NOT an authorization to release a copy of my medical records. I understand that I Can withdraw this authorization in writing at any time.

In the designated spots below please list Family Members or Friends that we may speak with if they should call or come into the office:

_____

_____

_____

_____ _____

Signature of Patient: Date:

_____

Name of Personal Representative & Relationship to Patient

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PATIENT NAME:_____D.O.B._____

ALLERGIES & REACTIONS (DRUG & FOOD):

_____

_____

LATEX ALLERGY: YES / NO

PREFERRED LAB: (CIRCLE ONE) QUEST / LABCORP / OTHER

PREFERRED IMAGING:(CIRCLE ONE) HOSPITAL / ADVANCED RADIOLOGY /PROGRESSIVE / OTHER

*****PREFERRED PHARMACY & LOCATION:_____**

MEDICATIONS & SUPPLEMENTS PLEASE INCLUDE ALL VITAMINS	DOSAGE	FREQUENCY	REASON FOR THIS MEDICATION

REVIEW OF SYSTEMS

MEDICAL HISTORY ❑ Asthma ❑ Depression ❑ Diabetes ❑ Heart disease ❑ High blood pressure ❑ High cholesterol ❑ Mental Illness ❑ Stroke ❑ Cancer If yes, what kind? _____❑ Other (Please list below):

PAST SURGICAL HISTORY:❑ Adenoidectomy ❑ Appendectomy ❑ Tonsillectomy ❑ Hernia Repair ❑ Other: (Please list below):

FAMILY HISTORY: ❑ Prostate Cancer ❑ Bladder Cancer ❑ Kidney Stones ❑ Other (Please list below):

DO YOU HAVE CHRONIC PROBLEMS RELATED TO THE FOLLOWING SYSTEMS? CIRCLE YES OR NO

CONSTITUTIONAL SYMPTOMS		
FEVER/CHILLS	Y	N
WEIGHT LOSS	Y	N
HEADACHE	Y	N
OTHER:		

EYES		
BLURRED VISION	Y	N
DOUBLE VISION	Y	N
PAIN	Y	N
OTHER:		

NEUROLOGICAL		
TREMORS	Y	N
DIZZY SPELLS	Y	N
NUMBNESS/TINGLING	Y	N
OTHER:		

ENDOCRINE		
EXCESSIVE THIRST	Y	N
TOO HOT/COLD	Y	N
TIRED/SLUGGISH	Y	N
DIABETES	Y	N

GASTROINTESTINAL		
ABDOMINAL PAIN	Y	N
NAUSEA/VOMITING	Y	N
INDIGESTION/HEARTBURN	Y	N
HEPATITIS/LIVER DISEASE	Y	N
OTHER:		

CARDIOVASCULAR		
CHEST PAIN	Y	N
VARICOSE VEINS	Y	N
HIGH BLOOD PRESSURE	Y	N
HEART DISEASE	Y	N
OTHER:		

HAVE YOU EVER SMOKED?	Y	N
IF YES, HOW LONG?		
DO YOU CURRENTLY SMOKE?	Y	N
DO YOU DRINK ALCOHOL?	Y	N
IF YES, HOW OFTEN/HOW MUCH?		

LIST APPROXIMATE DATES FOR THE FOLLOWING: MM/YYYY

LAST FLU SHOT: _____

LAST COLONOSCOPY:_____

LAST MAMMOGRAM:_____

LAST DEXA/BONE DENSITY SCREENING:_____

INTEGUMENTARY		
SKIN RASH	Y	N
BOILS	Y	N
PERSISTENT ITCHING	Y	N
OTHER:		

MUSKULOSKELETAL		
JOINT PAIN	Y	N
NECK PAIN	Y	N
BACK PAIN	Y	N
OTHER:		

EAR/NOSE/THROAT/MOUTH		
EAR INFECTION	Y	N
SORE THROAT	Y	N
SINUS PROBLEM	Y	N
OTHER:		

GENITOURINARY		
URINE RETENTION	Y	N
PAINFUL URINATION	Y	N
URINARY FREQUENCY	Y	N
OTHER:		

RESPIRATORY		
WHEEZING	Y	N
FREQUENT COUGH	Y	N
SHORTNESS OF BREATH	Y	N
OTHER:		

HEMATOLOGIC/LYMPHATIC		
SWOLLEN GLANDS	Y	N
BLOOD CLOTTING PROBLEM	Y	N
BLOOD TRANSFUSIONS	Y	N
BLOOD DISEASES	Y	N
OTHER:		

PSYCHOLOGIC		
ARE YOU GENERALLY SATISFIED WITH YOUR LIFE?	Y	N
DO YOU FEEL SEVERELY DEPRESSED?	Y	N
HAVE YOU CONSIDERED SUICIDE?	Y	N
OTHER:		

IF YOU ARE **FEMALE**, ARE YOU PREGNANT? DATE OF LAST MENSTRUAL PERIOD MO/YEAR	Y	N

Patient name: _____ D.O.B. _____ Today's date: _____

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION/MEDICAL RECORDS

PATIENT: _____ DATE OF BIRTH _____

PATIENT'S PHONE #_____ SOCIAL SECURITY # _____
(last 4 digits)

PLEASE CIRCLE REASON: SELF / 2ND OPINION / TRANSFERRING

PLEASE FORWARD REQUESTED RECORDS TO:

NAME: _____

PHONE #: _____

FAX #: _____

ADDRESS: _____

_____

TO BE OBTAINED FROM:

NAME: _____

PHONE #: _____

FAX #: _____

ADDRESS: _____

_____

THE UNDERSIGNED HEREBY AUTHORIZES AND REQUESTS HARNE, SONG, & WOO, MD., PA., TO PROVIDE COPIES OF MEDICAL RECORDS FOR THE ABOVE NAMED PATIENT. THIS AUTHORIZATION IS VALID FOR:

PLEASE CHECK:

____ ANY AND ALL INFORMATION RELATED TO PAST/PRESENT MEDICAL HISTORY, DIAGNOSIS, &TREATMENTS

____ THE MEDICAL RECORDS CONCERNING THE PERIOD: _____

I UNDERSTAND THAT THE MEDICAL RECORDS TO BE RELEASED MAY CONTAIN RELATED HIV STATUS, AIDS, VENEREAL DISEASES, ALCOHOL OR DRUG USE, CANCER DIAGNOSIS, OR MENTAL HEALTH SERVICES, AND I HEREBY AUTHORIZE THE RELEASE OF THIS INFORMATION. THIS AUTHORIZATION FOR DISCLOSURE IS VALID FOR A PERIOD OF ONE (1) YEAR AND MAY BE WITHDRAWN BY ME AT ANY TIME EXCEPT DURING AN ACTION TAKEN IN RESPONSE THEREON.

_____ _____
SIGNATURE OF PATIENT/GUARDIAN/GUARANTOR **DATE**

_____
NAME OF PERSONAL REPRESENTATIVE, & RELATIONSHIP TO PATIENT (IF APPLICABLE)