Dr. Benny S. Wang, MD
Board Certified in Neurology, EEG/EMG, and Sleep

IS YOUR VISIT TODAY RELATED TO A MOTOR VEHICLE ACCIDENT ACCIDENT? YES__ NO__
IS YOUR VISIT TODAY RELATED TO A WORKMAN'S COMPENSATION INJURY? YES__ NO__
IS YOUR VISIT TODAY RELATED TO ANY OPEN CASE PERTAINING TO AN INURY? YES__ NO__
PLEASE BE ADVISED THAT WE DO NOT TREAT THE ABOVE AND WILL NOT BE ABLE TO SEE YOU AS A PATIENT IF EITHER ONE OR ANY OF THE ABOVE ARE MARKED "YES"

First Name _____ Last Name _____

Date of Birth _____Social Security _____

Address _____

City _____State _____ Zip_____

Primary Phone_____ Secondary Phone _____

Gender: Male Female Email address _____

INSURANCE INFORMATION:
Primary Insurance company _____

Secondary Insurance company _____

MEDICAL CONTACT:
Primary or Referring Physician _____ Phone _____

PHARMACY INFORMATION:
Preferred Pharmacy _____ Phone _____

City _____ State _____ Zip _____

HIPPA AUTHORIZATION:
I GIVE PERMISSION TO THE FOLLOWING PER LISTED BELOW TO RECEIVE MEDICAL, FINANCIAL, AND/OR OTHER MEDICAL INFORMATION PERTAINING TO ME IN THE EVENT I CAN NOT BE REACHED.

EMERGENCY CONTACT:
First Name _____ Last Name _____

Relationship to patient _____ Phone # _____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE THAT MY OCCUR. I ALSO AUTHORIZE MY INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY MEDICAL CLAIMS.

X_____

Signature of Patient Date

Benny S. Wang, M.D.
Patient History Form

Patient Name: _____ D.O.B.: _____

Past Medical History:

Past Surgical History:

Last Hospital Visit- Indicate which hospital & (MO/YR):

Drug Allergies:

Medications:

Name of Medication:	Dosage/MG:	# of times a day:	Notes

Social History: Married Single Divorced Widowed

Smoker: Yes No Alcohol: If yes, How much per day/week/month: _____ No Drugs: Yes No

If Yes, How many packs per day: _____

Woman: Date of last menstrual cycle: _____ # of miscarriages: _____

Family Medical History:

Texas
Electrodiagnostics, PLLC

PATIENT AUTHORIZATION TO RELEASE
PROTECTED HEALTH INFORMATION TO THE DESIGNATED REPRESENTATIVE(S)

I, _____, give my authorization to release my protected health information; including results of my laboratory tests, x-ray and/or other test results to the following designated representative(s):

Patient Initials

_____ My Spouse (Name) _____

_____ My Child (Name) _____

_____ Other (Name) _____

_____ Personal Representative _____

_____ May be left on my answering machine at home.

_____ May be left on my answering machine at work or cell.

_____ MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF.

_____ _____
Patient Signature Date

_____ _____
Witness Date

As a patient, you have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, the office must receive the revocation in writing to: Texas Electrodiagnostics, PLLC, 9305 Pinecroft Dr., Ste 304, The Woodlands, Texas 77380 or by fax at: 1-866-936-7076. I understand that the written revocation must be signed and dated with a date that is later than the authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Financial Agreement

Thank you for your visit with Texas Electrodiagnostics PLLC and trusting us to help you with your health care needs. The purpose for the financial agreement is to answer any questions related to patient and insurance responsibility for services rendered. We ask that you read this carefully and if you have any questions please ask our staff or billing service for assistance. Please sign where indicated acknowledging your acceptance and understanding of this agreement. You will be given a copy of this agreement for your records.

Insurance

Your insurance coverage is a contract between you and the insurance company, and it is your responsibility to know your insurance benefits. As a courtesy, we will bill your primary, secondary, and additional insurance companies (as applicable) provided we are given accurate information at the time of your visit and when requested. We will submit your claims and assist you in any way we reasonably can to help get your claims processed. If information is not supplied to us or your insurance company, you will be billed, and payment in full will be your responsibility and will be expected within 30 days of receipt of statement.

Medicare

We are a Medicare participant. You are responsible for your co-insurance, any deductibles that have not yet been met, and services that are identified as patient responsibility on your Medicare Explanation of Benefits. We strive to inform our Medicare patients of services that will not be covered.

Managed Care

Many patients are enrolled in Managed Care Products. In order for us to obtain referrals and/or pre-authorizations for procedures, it is important that we have your current insurance information. Depending on individual policies, your procedure may not be a covered benefit. It is your responsibility to check for optimal coverage and policy limitations, and to obtain referrals as required by your insurance company. Please contact your insurance company with questions regarding your coverage.

Patient Responsibility for Payment

You are responsible for payment of any co-payment, co-insurance, deductible or service not covered by your insurance, handling, collection or attorney fees. If you do not have insurance, you are responsible for payment of all services. Co-payments, deductibles, and/or coinsurance are due at the time of your service. Patient due balances noted on your monthly statement are due upon receipt. Charges for minor children will be billed to the parent with whom the child resides. A minor is considered to be any person under the age of 18.

Payment Options

We understand financial circumstances vary from patient to patient. If you are unable to pay your patient due balance in full, you must call our billing office at (888) 445-2455 to make payment arrangements. We may offer uninsured patients a discount for office visits paid on the date of service. We accept cash, check and all major credit cards

Non-Payment

Failure to pay will result in your account being referred to a collection agency, which may affect your credit. You must contact our collection analyst to discuss payment arrangements. Balances turned over to a collection agency will result in an additional collection fee equal to 28% of the total balance turned over.

No Shows and NSF Checks

No shows will result in a $75 fee (please see no-show policy). NSF checks or payments will result in a $25 fee. We will also recover any additional fees charged to us due to other reversals of payments.

I have received this financial policy, and understand regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand delinquent accounts will be referred to a collection service or an attorney. I agree to pay for all costs and expenses, including reasonable attorney fees. I also acknowledge that I have received a copy of this financial agreement for my records.

Patient Signature	Printed Name	Date
Patient/Guardian Signature	Printed Name	Date

Benny S. Wang, M.D.
Board Certified in Neurology and Neurophysiology
EEG, EMG, Sleep Study
17191 St. Luke's Way Ste. #200, The Woodlands, Texas 77384
1020 Riverwood Court Ste. #310, Conroe, Texas 77304
832-510-6553

Dear Patients:

Please check one of the following boxes:

[ ] I am willing to provide my email address: _____ AND learn how to use the patient portal and electronic communications with Dr. Wang's office.

[ ] I prefer not to provide my email address or do not wish to use the patient portal.

_____
Patient Signature

_____
Print Name

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Dear Patients:

When it comes to your medical care, you always have a choice in terms of doctors, testing facilities and medications. Your insurance company will always have preferred medications and testing facilities (which usually cost them less) but may or may not be better for you from medical or financial standpoint. You have the right to choose.

For complete disclosure I would like to state that I have either stocks, directorship, partnership, speaker bureau or other forms of financial interests in the following healthcare companies:

Johnson and Johnson, Pfizer, Cyberonics, Aspire, Conroe Premier Imaging, Reliant Rehab, Bluebonnet pharmacy, Woodlands Premier Sleep Center, OneStep Diagnostics (at Red Oak), Physician Ancillary Services, Frontier Toxicology, Montgomery ER, Livingston ER, Wallisville ER.

Sincerely,

_____
Benny Wang, M.D. 09-20-14

_____
Patient Signature Date