United Interventional Pain Management Center

132-61 41st Rd, 201. Flushing, NY 11355

(718)-355-9119

Patient's Name Last 姓氏 First 名 Middle 病人姓名		Sex 性別 Male 男 Female 女
Patient's Address 病人住址 **Email 电子邮箱:**		Chinese Name 中文姓名
Social Security Number 社會安全號	Date of Birth 出生日期	Place of Birth 出生地
Marital Status 婚姻狀況	Home Phone 住宅電話	Cell Phone 手機電話
Emergency Contact 緊急聯絡人	Relationship 關係	Tel. No. 聯絡人電話
Guardian Name (Patients Under 18) 監護人姓名(十八歲以下病人)	Guardian SSN 監護人社會安全號碼	Guardian Tel. 監護人聯系電話
Primary Language 主要語言	Secondary Language 第二語言	
Primary Health Insurance 主要醫療保險		
Secondary Health Insurance 第二醫療保險		

I hereby authorize Drs. Wensong Li, Peter Zheng, Jinghua He and their medical staffs to perform any necessary routine examinations, diagnostic tests and procedures, injections and treatments on me.
本人授權李尉崧, 郑双武， 赫靖华醫生及其醫療人員做任何有關病情的各項檢查化驗, 注射和治療.
I hereby authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicaid, Medicare, commercial insurances and other health plans to Dr. Wensong Li. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.
本人允許李/郑/赫醫生及其醫務所向我的保險公司獲取一切有關資料, 以了解我的受保情況並且要求保險公司替我支付醫療費用. 我允許我的保險公司, 包括 Medicare, Medicaid, 私營保險和其他保險公司, 向醫生及其醫務所支付我的醫療費用. 本授權文件在書面取消前一直有效, 本文件的影印件將同樣有效.

I understand that I am financially responsible for any balance if my insurance is invalid or I have deductible and copays. I will provide my credit card number and give permission to draw payments from it If the doctors' office first attempt to file a claim is denied, it would charge the card for the bills (for larger bills, it would take $500 off the credit card each month.) I will pay the bill in cash prior to providing care if I have no credit card. I understand that I will get fully refund if my insurance make payment to all claims.

本人明白如果我的醫療保險無效，或有自付部分, 我願意負擔一切診金和醫療費用. 如果我的保险公司拒绝向我的医生支付我的医疗费用，我在此提供我本人的信用卡账号并允许我的信用卡账户直接向醫生及其醫務所支付我的医疗费用（大额费用可分次支付，每次$500）。如果我无信用卡，在诊治以前，我必须以现金支付全部医疗费用。我明白一旦我的保险公司支付了全部医疗账单，我将获得全数退费（不含信用卡公司手续费）。

I certify that the above information is accurate and correct. 我保證以上資料准確無誤.

_____ _____

Patient or Guardian Signature 病人或監護人簽名 Date 日期