HealthTrac Family Wellness

Patient History Information

Please complete this form and then return to the receptionist. **- Please PRINT -**

Por Favor complete esta forma y regresela a la recepcionista.

Date/ *Fecha*: _____ Patient No: _____

Last Name *Apellido*: _____ **First and Middle Name** *Primer Nombre*: _____ **Height**: *Altura*: ____' ____"

Age/ *Edad*: _____ **Date of Birth/** *Fecha de Naciemiento*: _____ ❑ **Male/***Masculino* ❑ **Feimale/***Femenino* **Weight**: *Peso*: _____ lb.

Home Address/ *Direccion*: _____

City/ *Ciudad*: _____ **State/** *Estado*: ____ **Zip Code/** *Postal*: _____

Telephone **Home** *Casa*: _____ **Work** *Trabajo*: _____ **Mobile** *Celular*: _____

Social Security # *Seguro Social*: _____ **Email** *Email* : _____

Occupation/ *Ocupaccion*: _____ **Employer/***Empleador*: _____

❑ **Full-Time Job** *Empleado* ❑**Part-Time Job** *Medio Tiempo* ❑ **Multiple Jobs** *Multiples Trabajos* ❑**Employed** *Trabajador Independiente* ❑ **Retire** *Retirado* ❑ **Suspended** *Suspendido* ❑**Unemployed** Desempleado

Work Address/ *Direccion de Trabajo*: _____

City/ *Ciudad*: _____ **State/** *Estado*: _____ **Zip code/** *Postal*: _____

Marital Status/ *Estado Marital*: ❑ **Single/***Soltera* ❑ **Married/***Casada* ❑ **Divorced/** *Divorciada* ❑ **Widowed/***Viuda*

Spouse's Name *Nombre Esposo*: _____ **Number of Children** *Numero de Hijos*: _____ **Ages** *Edades*: _____

Phone Number/ *Telefon* _____

Emergency Contact Person/ *Contacto de Emergencia*: _____ **Phone Number/***Telefono*: _____

Have you received chiropractic care in the past? ❑ **Yes/***Si* ❑ **No/** *No* **When?** *Cuando?* _____

Ha recibido cuidado chiropractico en el pasado ?

If yes, please give name of the Chiropractor:

Si es si, Proveame el nombre del chiropractor: _____

Please describe the reason for previous care:

Por Favor describame la razon de su anterior cuidado: _____

Name of your Medical Doctor

Nombre de su Doctor: _____

List the name of your health insurance company:

Nombre su aseguranza medica: _____

Policy number is:

Numero de la poliza: _____

Reason(s) for seeking chiropractic care starting with the most severe:

Razones por la que busca cuidado chiropractico empieze por el mas severo

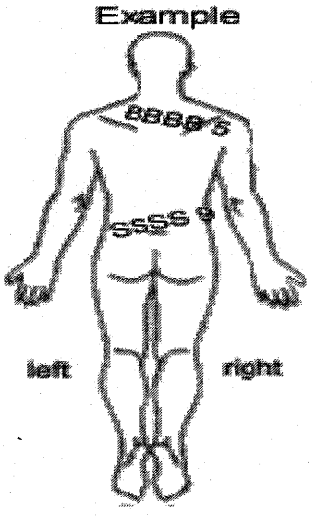
	Chief Complaint *Motivo de la Consulta*	**Approximate Date Started** *Dia que Empezo*
1.	_____	_____
2.	_____	_____
3.	_____	_____

Areas of injury or discomfort:

Areas que tiene el dano o la molestia

On the following chart please mark area(s) of injury or discomfort (see example). Mark all areas with the appropriate symbols and indicate the degree of pain on a scale from 1 (discomfort) to 10 (extreme pain).

En el dibujo abajo marque el area que tiene el dano o que le molesta (vea el ejemplo) Marque todas las areas apropiadamente con simbolo indicando el dolor empezando con 1 (molestia) con 10 (extremo dolor)



NNNN **Numbness** entumecimiento

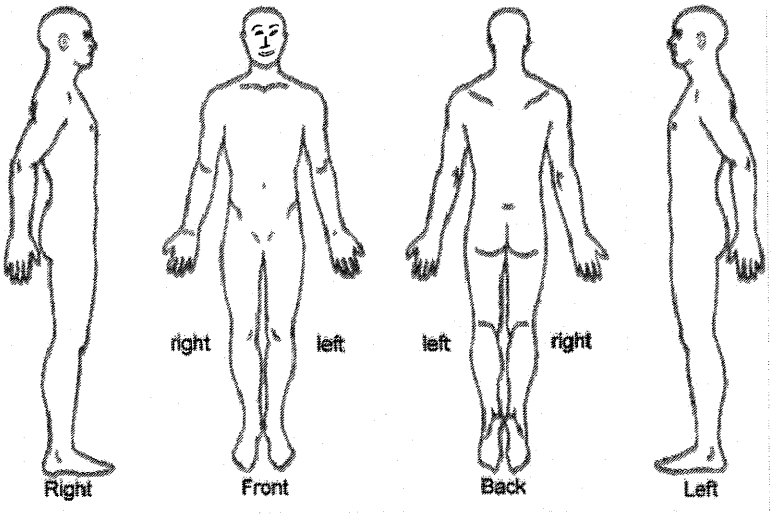
PPPP **Pins & Needles** *hormigueo*

BBBB **Burning** *ardor*

AAAA **Aching** *Dolor*

SSSS **Stabbing** *Punalada*

Circle any area of pain not represented by a symbol. *Circule el area de dolor representada por el simbolo*



Please indicate any medications you are currently taking:

Porfavor indique cualquier medicamento que usted este actualmente tomando:

- ❑ **Blood pressure**/ *Presion*
- ❑ **Muscle relaxants**/ *Relajente Muscular*
- ❑ **Stimulants**/ *Estimulante*
- ❑ **Blood thinners**/ *Anticoagulante*
- ❑ **Steroids**/ *Esteroides*
- ❑ **Birth control pills**/ *Anticopcetiva*
- ❑ **Stimulants**/ *Estimulantes*
- ❑ **Pain killers** (*including Aspirin*)
- ❑ **Insulin**/ *Insulina*
- ❑ **Antibiotics**/ *Antibiotico*
- ❑ **Sleeping Pills**/ *Pastilla para dormir*

❑ **Others** /*Otras*: _____

Name of nutritional supplements and/or dietary aids:

Alguna nutricion suplementaria o ayuda para la alimentacion: _____

Revision de los sistemas, Por favor anote cualquier condicion que halla tenido en el pasado que que tenga ahora:

Now	Past		Now	Past		Now	Past	
❑	❑	**Back Pain** *Dolor espalda*	❑	❑	**Chest Pain** *Dolor de Pecho*	❑	❑	**Difficulty Urinating** *Dificultad para Orinar*
❑	❑	**Neck Pain** *Dolor cuello*	❑	❑	**Poor Circulation** *Poca Circualcion*	❑	❑	**High BP** *Presion Alta*
❑	❑	**Shoulder/Arm Pain** *Dolor de Hombro*	❑	❑	**Skin Problems** *Problema de piel*	❑	❑	**Arrhymia** *Arritmia*
❑	❑	**Hip/Leg Pain** *Dolor de pierna y cadera*	❑	❑	**Colon Trouble** *Problemas del colon*	❑	❑	**Frequent Infections** *Infecciones*
❑	❑	**Sciatica** *Ciatica*	❑	❑	**Stomach Trouble** *Problema del Estomago*	❑	❑	**Difficulty Breathing** *Dificulatad para respirar*
❑	❑	**Arthritis** *Arthritis*	❑	❑	**Kidney Problems** *Problema de los rinones*	❑	❑	**Liver Trouble** *Problema del higado*
❑	❑	**Asthma** *asma*	❑	❑	**Easy Bruising** *Hematomas*	❑	❑	**Pregnancy** *Embarazada*
❑	❑	**Prostate Problems** *Problema de la prostata*				❑	❑	**Menstrual Problems** *Problema menstrual*
❑	❑	**None of the above** *Ninguno*	❑	❑	**None of the above** *Ninguno*	❑	❑	**None of the Above** *Ninguno*

Have you ever: *Alguna vez:*

Comments: *Comentarios:*

Had any accidents, falls, traumas, or injuries:
accidentes, caidas, traumas : ❑ **Yes/***Si* ❑ **No** _____

Been hospitalized/ *Ha estado Hospitalizado* : ❑ **Yes/***Si* ❑ **No** _____

Had a broken bone / *Algun hueso roto:* ❑ Yes/*Si* ❑ **No** _____

Had surgery / *Ha tenido cirugia:* ❑ **Yes/***Si* ❑ **No** _____

Been treated for an emotional disorder
Ha estado en tratamiento para un trastorno emocional: ❑ Yes/*Si* ❑ No _____

Been bedridden for more than a week
Ha estado postrado en una cama por mas de una semana: ❑ Yes/*Si* ❑ No _____

Health/Risk Factors / *Riesgo de Salud Factores:*

Comments / *Comentarios:*

Do you smoke? *Fuma?* ❑ **Yes/***Si* ❑ **No** If yes ❑ ❑ Occasional ❑ Light ❑ Medium ❑ Heavy

Do you drink alcohol? *Toma alcohol* ❑ **Yes/***Si* ❑ **No** If yes ❑ Once/Week ❑ 2-5 Times/Week ❑ Daily

Do you have a healthy diet?
Tiene una dieta saludable ? ❑ **Yes/***Si* ❑ **No** _____

Do you exercise regularly?
Hace ejercicios regulares ? ❑ **Yes/***Si* ❑ **No** If yes ❑ Occasional ❑ 3-5 Times/Week ❑ Daily

Do you sleep well? *Duerme bien ?* ❑ **Yes/***Si* ❑ **No** _____

Is your job stressful?
Es su trabajo estresante ? ❑ **Yes/***Si* ❑ No _____

Do you drink caffeine? *Tomas cafeina?* ❑ Yes/*Si* ❑ No If yes If yes ❑ Occasional ❑ Daily

What is your dominate hand?
Cual es tu mano dominate? ❑ **Right** / *Derecha* ❑ **Left** / *Izquierdo* ❑ **Both** /*Ambidextro*

Can you think of any other habit or activity that has a positive or negative effect on your health? ❑ **Yes/***Si* ❑ No
Puede usted pensar en otra actividad o habito que le produzca un efecto negativo o positivo en su salud?

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	Signature	Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____
have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____	_____
Signature	Date

HealthTrac Family Wellness, Inc

On Track to Great Health

Consent For Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by **HealthTrac Family Wellness** (also HTFW) for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of **HTFW**. I understand that diagnosis or treatment of me by **Dr. George Hui, D.C.** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. **HealthTrac Family Wellness** is not required to agree to the restrictions that I many request. However, if **HTFW** agrees to a restriction that I request, the restriction is binding on **HTFW** and **Dr. George Hui, D.C.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Dr. George Hui, D.C.** or **HTFW** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **HTFW**'s Notice of Privacy Practices prior to signing this document. The **HTFW**'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of **HTFW**. This Notice of Privacy Practice also describes my rights and **HTFW**'s duties with respect to my protected health information.

HealthTrac Family Wellness reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practice by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or PR/ Date Please Print Name of Patient or PR

_____

Description of Personal Representative's Authority

HealthTrac Family Wellness, Inc.

Authorization for Use or Disclosure of Information for Purposes Requested by Chiropractor

In this document, "I" and "my" refer to the patient,
and "Chiropractor" refers to HealthTrac Family Wellness.

I hereby authorize Chiropractor to (check those that apply):
_____ use the following protected health information, and/or
_____ disclose the following protected health information to the following entity:

_____

Information to be used or disclosed:
Date of service: _____
Type of service: _____
Level of detail to be released: _____
Origin of information: _____

This protected health information is being used or disclosed for the following purposes:

_____

This authorization shall be in force and effect until _____,
at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer of the Chiropractor, at 4720 Peachtree Industrial Blvd. Suite 104, Norcross, GA 30071. I understand that a revocation is not effective to the extent that Chiropractor has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Chiropractor will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights) and/or to refuse to sign this authorization.

_____ _____
Signature of Patient or Personal Representative Printed Name of Patient

_____ _____
Date of Signing Description of Personal Representative's Authority

Personal Injury Consultation Form

Forma para consultar su Lesion Personal

Name: **Date:**
Nombre: _____ *Fecha:*_____

Date of Accident:
Dia que ocurrio el accidente: _____

1. **At impact did you experience a flash in your head?** _____**Yes** / *Si*
   Cuando recibio el impacto siento mareo o calentura ? _____ **No** / *No*
   Did you lose consciousness? _____**Yes** / Si
   Perdio el conocimiento? _____**No** / No
2. **Immediately following the accident how did you feel?**
   Inmediatamente siguiendo el accidente como se sintio, explique por favor ?
   _____
   Did you become? (Please circle)
   Que ha sentido ? (Por favor circule sus respuestas)
   Confused/ *Confundido*, **Disoriented**/ *Desorientado*, **Light headed**/ *Mareado,* **Nauseated**/ *Nauseas,*
   Blurred vision/ *Vision borrosa*, **Ringing/Buzzing in ears**/ *Zumbido en los timpanos*
3. **Are you currently experiencing? (Please circle)**
   Que esta actualmente experimentando ? (Por Favor circule su respuesta)
   Restlessness/ *Inquietud*, **Irritable**/ *Irritabilidad*, **Difficulty concentrating and remembering**/ *Dificultad para concentrarse y recorder,* **Sleeplessness** / *Insomnio,* **Forgetfulness** / *Olvida muy rapidamente*,
   Reduced tolerance to heat or cold/ *No tolera el caliente ni el frio*
4. **Over the next few hours and days, what symptoms did you feel?**
   En las proximas horas y dias, que sintomas ha tenido ?
   _____
   _____
   _____
5. **Please tell us how your accident happened.**
   Cuéntenos cómo ocurrió su accidente:
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
6. **Any other symptoms to report?** *Algun otro sintoma que tenga para reportarlo ?*
   _____
7. **Was your car moving at impact?** **How fast?/**
   Su carro estaba en movimiento al recibir el impacto? _____**Yes** / *Si* ____**No**/ *No* *Que tan rapido ?* _____.
8. **Was the other car moving?** **How fast?**
   Estaba el otro carro en movimiento ? _____**Yes** / *Si* ____**No**/ *No* *Que tan rapido ?* _____.
9. **Which way was your body facing at impact?** **Straight** **Right** **Left**
   En que posicion estaba su cuerpo cuando recibio el impacto? ___ *Derecho* ____*Derecha* ____*Izquierda*
10. **Which way was your head facing at impact?** **Straight** **Right** **Left**
    En que direccion estaba su cabeza cuando recibio el impacto? ___ *Derecho*____*Derecha* ____*Izquierda*
11. **Were you surprised by the impact**
    Fue usted sorprendido por el impacto ? _____**Yes** /*si* _____**No** / *No*
12. **Does your car have a headrest?**
    Tiene su carro un cabezal ? _____**Yes** /*si* _____**No** /*No*

Patient Insurance Information
病人保險資料

Please check any and all insurance coverage you or your spouse has applicable in this case.
請填寫任何及所有保險您或您的配偶適用於這種事例。

- o Auto accident 車禍意外
- o BCBS 藍十字藍盾
- o Major Medical 病醫療保險
- o Worker's Compensation 工人賠償金
- o Other 其它

Insurance Identification #
保險標識號碼:_____

Date of Accident
事故日期:_____

Insurance Name 保險名稱:_____ Policy # 保單號碼:_____

Address/Phone
地址 / 電話號碼_____

Adjuster 險損估計人:_____ Claim# 索賠號碼:_____

Medical and Legal Information
醫療和法律資料

Name of Attorney 律師姓名:_____ Phone # 電話號碼:_____

Address
地址:_____

Pregnant: _____Yes 是 懷孕: _____No 不是

Pacemaker: _____Yes 是 起搏器: _____No 不是

Family Physician and Phone Number
家庭醫生名字和電話: _____

Patient Agreement
病人協議

Assignment and Release

I, the undersigned, have insurance coverage with _____ and assign directly to HealthTrac Family Wellness, Inc all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

分配和釋放

我，簽署人，在_____保險公司有保險范圍和，如果有的話，直接分配所有的醫療福利給 HealthTrac Family Wellness Inc，否則支付給我提供的服務。我明白我要負責所有的財務費用是否支付保險。本人批准醫生釋放所有必要信息來確保支付保險賠償。本人批准使用此簽名我所有的保險意見書。

_____

Signature of Insured/Guardian
保險人 / 監護人簽名

Doctor's Lien

Medico Embargo

Claim#
*Numero De Reclamo:*_____

Date of Accident
*Fecha del accidente:*_____

Patient Name
*Nombre del Paciente:*_____

Insured Name
*Nombre del asegurado:*_____

Attorney
*Abogado:*_____

I hereby authorize and direct my attorney, insurance company or liability insurance adjustor to promptly pay Dr. Hui any monies due and owing him for medical fees incurred either from this accident or by reason of any other bills that are due to his office and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect and fully compensate said doctor.
Yo por este medio autorizo directamente a mi abogado, aseguranza, adjustador a pagarle prontamente al Dr. Hui cualquier dinero que provenga de mis gastos medicos ocasionados por el accidente or por cualquier razon por la que haya que pagar los recargos medicos retenidos como asentamiento, juicio o veredicto y lo que sea necesario para adecuadamente proteger el pago del doctor.

I fully understand that I am directly and fully responsible to Dr. Hui for all fees incurred in his office. This agreement is made solely for the doctor's additional protection. I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fees.
Yo completamente entiendo que solo yo directamente soy responsible de todos los gastos incurridos en la oficina del Dr. Hui. Este acuerdo se hace unicamente para adicional proteccion para el doctor.

I authorize Dr. Hui to furnish to any attorney, insurance company or adjustor with any and all medical and/or financial information as requested.
Yo autorizo a Dr. Hui a proporcionar, a la compania aseguradora o el ajustador con cualquier detalle medico o financiero que ellos requieran.

I agree that Dr. Hui be given Power of Attorney to endorse/sign my name on any and all checks for payment of my medical bill.
Yo acuerdo al Dr. Hui adarle el poder de fimar con mi nombre cualquier cheque para los pagos de los biles medicos.

I understand that this lien is effective for up to five years after my last office visit.
Yo entiendo que esta conexion es efectiva por mas de cinco anos despues de mi ultima visita.

A photocopy of this agreement shall be considered as effective and valid as the original.
Una fotocopia de este acuerdo es considerado tan efectivo y valido como la original.

Patient Signature
Firma: _____

Date
*Fecha:*_____

The undersigned being either the attorney or insurance company representative of record for the above patient does hereby agree to observe all the terms of the above and agree to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect Dr. George Chi Hui, D.C.

Attorney's Signature: _____ Date: _____

HealthTrac Family Wellness
On Track to Great Health

4720 Peachtree Ind. Blvd., Suite 104 Norcross, GA 30071
Telephone: (678)740-9401 Fax: (770)670-6518

IRREVOCABLE ESCROW INSTRUCTION AND AGREEMENT

The undersigned patient (hereinafter "Patient") in order to induce HealthTrac Family Wellness (hereinafter the "Provider") to extend credit to the Patient, hereby irrevocable instruct my attorney and escrow agent, to pay to Provider the full amount of any bill for services rendered by the Provider, from the proceeds of my personal injury settlement or award within ten (10) days of receipt by him of same, excepting time for any negotiable instrument to clear.

The escrow instruction and agreement is irrevocable by me and is being used to include the Provider to provide continued medical services from my accident.

_____
Patient Signature

_____

_____

_____
Patient Name and Address

Understood and agreed to by:

Dated:

_____
HealthTrac Family Wellness

_____
Provider Signature

Dated:

By: _____

Its: _____

HealthTrac Family Wellness

NO SHOW / CANCELLATION POLICY

Our goal is to meet the needs of our patients and we will make every effort to efficiently schedule your appointments. **In return, it is your responsibility to make every effort to keep your scheduled appointments and arrive promptly at the time instructed.** However, we realize that unanticipated events may prevent you from keeping your appointment. In fairness and consideration to our other patients, we hereby request that you notify our office immediately when you realize you will not be able to keep your appointment.

If you need to cancel or reschedule your appointment, you must do so **at least 24 hours before your scheduled office appointment** to avoid paying a fee. In an effort to see patients promptly at the schedule time, this office does not double-book appointments; therefore, the 24 hour notification is necessary so that we may schedule other patients needing immediate appointments.

Missed office appointment fee is $50.00

**Fees are not covered by insurance and must be paid before you can reschedule your appointment.

我們的目標是滿足患者的需求，我們將盡一切努力有效地安排您的預約。同时，您也有責任盡一切努力保持預定的预約，並在约定的時間及時到達。但是，我們意識到，突发事件可能會妨碍您准时到达您的预约。出於對我們其他患者的公平和考慮，我們特此请求您，當您意識到無法准时到达預約時，應立即通知我們診所。

如果您需要取消或重新安排预约，則必須在预約时间的至少 24 小時前取消或重新安排预約，以免支付費用。為了及時在安排的時間看病人，本诊所不重複預約。因此，有必要提前 24 小時通知我们，以便我們安排其他有需要立即預約的患者。错过预约需支付費用如下：$50. 00。

**費用不在保險包含範圍之內，必須在重新安排預約之前支付。

Nuestro objetivo es satisfacer las necesidades de nuestros pacientes y haremos todo lo posible para programar sus citas de manera eficiente. ***A cambio, es su responsabilidad hacer todo lo posible para cumplir con sus citas programada y llegar puntualmente a la hora indicada.*** *Sin embargo, nos damos cuenta de que los eventos imprevistos pueden impedir que cumpla con su cita. Para ser justos y considerados con nuestros otros pacientes, le solicitamos que notifique a nuestra oficina de inmediato cuando se dé cuenta de que no podrá asistir a su cita.*

Si necesita cancelar o reprogramar su cita, debe hacerlo ***al menos 24 horas antes de su cita programada para evitar pagar una tarifa.*** *En un esfuerzo por ver a los pacientes puntualmente a la hora programada, este consultorio no reserva citas dobles; por lo tanto, la notificación de 24 horas es necesaria para que podamos programar otros pacientes que necesiten citas inmediatas.*

La cuota para una cita perdida es: $ 50.00

** Las tarifas no están cubiertas por el seguro y deben pagarse antes de que pueda reprogramar su cita.

Patient Signature / 病人签名/ *Firma del paciente*

Date / 日期/ *Fecha*

HealthTrac Family Wellness

NO SHOW / CANCELLATION POLICY

Our goal is to meet the needs of our patients and we will make every effort to efficiently schedule your appointments. **In return, it is your responsibility to make every effort to keep your scheduled appointments and arrive promptly at the time instructed.** However, we realize that unanticipated events may prevent you from keeping your appointment. In fairness and consideration to our other patients, we hereby request that you notify our office immediately when you realize you will not be able to keep your appointment.

If you need to cancel or reschedule your appointment, you must do so **at least 24 hours before your scheduled office appointment** to avoid paying a fee. In an effort to see patients promptly at the schedule time, this office does not double-book appointments; therefore, the 24 hour notification is necessary so that we may schedule other patients needing immediate appointments.

Missed office appointment fee is $50.00

**Fees are not covered by insurance and must be paid before you can reschedule your appointment.

我們的目標是滿足患者的需求，我們將盡一切努力有效地安排您的预約。同时，您也有責任盡一切努力保持預定的預約，並在约定的時間及時到達。但是，我們意識到，突发事件可能會妨碍您准时到达您的预约。出於對我們其他患者的公平和考慮，我們特此请求您，當您意識到無法准时到达預約時，應立即通知我們診所。

如果您需要取消或重新安排预約，則必須在预約时间的至少 24 小時前取消或重新安排预約，以免支付費用。為了及時在安排的時間看病人，本诊所不重複預約。因此，有必要提前 24 小時通知我们，以便我們安排其他有需要立即預約的患者。错过预约需支付費用如下：$50.00。

**費用不在保險包含範圍之內，必須在重新安排预約之前支付。

Nuestro objetivo es satisfacer las necesidades de nuestros pacientes y haremos todo lo posible para programar sus citas de manera eficiente. ***A cambio, es su responsabilidad hacer todo lo posible para cumplir con sus citas programada y llegar puntualmente a la hora indicada.*** *Sin embargo, nos damos cuenta de que los eventos imprevistos pueden impedir que cumpla con su cita. Para ser justos y considerados con nuestros otros pacientes, le solicitamos que notifique a nuestra oficina de inmediato cuando se dé cuenta de que no podrá asistir a su cita.*

Si necesita cancelar o reprogramar su cita, debe hacerlo ***al menos 24 horas antes de su cita programada para evitar pagar una tarifa.*** *En un esfuerzo por ver a los pacientes puntualmente a la hora programada, este consultorio no reserva citas dobles; por lo tanto, la notificación de 24 horas es necesaria para que podamos programar otros pacientes que necesiten citas inmediatas.*

La cuota para una cita perdida es: $ 50.00

** Las tarifas no están cubiertas por el seguro y deben pagarse antes de que pueda reprogramar su cita.

Patient Signature / 病人签名/ *Firma del paciente*

Date / 日期/ *Fecha*