

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 Nacimiento: _____ Male/Masculino Female/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/ Ocupacion: _____ 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? _____

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)

Example

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:

- | | | |
|--|--|--|
| <input type="checkbox"/> Blood pressure/ Presion | <input type="checkbox"/> Steroids/ Esteroides | <input type="checkbox"/> Insulin/ Insulina |
| <input type="checkbox"/> Muscle relaxants/ Relajante Muscular | <input type="checkbox"/> Birth control pills/ Anticopcetiva | <input type="checkbox"/> Antibiotics/ Antibiotico |
| <input type="checkbox"/> Stimulants/ Estimulante | <input type="checkbox"/> Stimulants/ Estimulantes | <input type="checkbox"/> Sleeping Pills/ Pastilla para dormir |
| <input type="checkbox"/> Blood thinners/ Anticoagulante | <input type="checkbox"/> Pain killers (including Aspirin) | |

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

Have you ever: Alguna vez:

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

Comments: Comentarios:

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?

Yes/Si No

Tiene una dieta saludable?

Do you exercise regularly?

Yes/Si No

Hace ejercicios regulares?

If yes Occasional 3-5 Times/Week Daily

Do you sleep well? Duerme bien?

Yes/Si No

Is your job stressful?

Yes/Si No

Es su trabajo estresante?

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 may 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: _____
Nombre: _____

Date: _____
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?**

Su carro estaba en movimiento al recibir el impacto? _____ **Yes / Si** _____ **No/ No**

How fast?/

Que tan rapido? _____

8. **Was the other car moving?**

Estaba el otro carro en movimiento? _____ **Yes / Si** _____ **No/ No**

How fast?

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。

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

Insurance Identification #

保險標識號碼: _____

Date of Accident

事故日期: _____

Insurance Name

Policy #

保險名稱: _____ 保單號碼: _____

Address/Phone

地址 / 電話號碼 _____

Adjuster

Claim#

險損估計人: _____ 索賠號碼: _____

Name of Attorney

Phone #

律師姓名: _____ 電話號碼: _____

Address

地址: _____

Pregnant: Yes 是

Pacemaker: Yes 是

懷孕: No 不是

起搏器: No 不是

Family Physician and Phone Number

家庭醫生名字和電話: _____

**Medical and
Legal
Information**

醫療和法律資
料

**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 _____ 保險公司有保險範圍和, 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# _____ **Date of Accident**
Numero De Reclamo: _____ *Fecha del accidente:* _____

Patient Name _____ **Insured Name**
Nombre del Paciente: _____ *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, ajustador 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 responsable 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: _____

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。同時，您也有責任盡一切努力保持預定的預約，並在約定的時間及時到達。但是，我們意識到，突發事件可能會妨礙您準時到達您的預約。出於對我們其他患者的公平和考慮，我們特此請求您，當您意識到無法準時到達預約時，應立即通知我們診所。

如果您需要取消或重新安排預約，則必須在預約時間的至少 24 小時前取消或重新安排預約，以免支付費用。為了及時在安排的時間看病人，本診所不重複預約。因此，有必要提前 24 小時通知我們，以便我們安排其他有需要立即預約的患者。錯過預約需支付費用如下：\$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 / 病人簽名 / Firma del paciente

Date / 日期 / Fecha

HealthTrac Family Wellness

NO SHOW / CANCELLATION POLICY

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****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 / 病人簽名/ Firma del paciente

Date / 日期/ Fecha