Wynnshang C. Sun, M.D., APC

9850 Genesee Ave. Suite 870
La Jolla, California 92037
Phone: (858) 452-7040 Fax: (858) 452-7137

Patient Registration

Name _____ Date of Birth _____

Preferred Name _____ Social Security Number _____

Home phone (_____) _____ Cell phone (_____) _____ Consent to text ☐ Yes ☐ No

Physical Address _____ City, State, Zip _____

Mailing Address_____ City, State, Zip _____

Employer _____ Work phone (_____) _____

Emergency Contact:

Name _____ Relation _____ Number _____

Preferences *(Name, location, number):*

Pharmacy _____

Laboratory _____

Federal Demographic Information

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients. Check any that apply.

Ethnicity: ☐ Decline Response ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ Decline Response ☐ American Indian or Alaskan Native ☐ Black or African American ☐ White

☐ Native Hawaiian ☐ Other Pacific Islander ☐ Asian ☐ Other: _____

Sexual Orientation & Gender Identity

The following questions are **optional**:

Preferred Pronouns: ☐ She, her, hers ☐ He, him, his ☐ They, them, theirs ☐ Other: _____

Sexual Orientation: ☐ Lesbian, gay or homosexual ☐ Straight/Heterosexual ☐ Bisexual ☐ Other: _____

Gender Identity: ☐ Female ☐ Male ☐ Female-to-Male Transgender ☐ Male-to-Female Transgender

☐ Genderqueer, neither exclusively male nor female ☐ Other: _____

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It is our office policy to try to contact every patient by phone whenever follow-up information needs to be given for test results, further care needs, etc. Most of these calls will be made during business hours, and we often encounter only message machines or voice mail when we make calls. Please provide the telephone number that you would prefer us to use to contact you about your medical information and needs.

Daytime Telephone (_____) _____ - _____

Please check one of the following to indicate your wishes:

_____ 1. Dr. Sun or his staff may leave medical information on my answering machine or voice mail. This may include test results, diagnosis, and recommendations.

_____ 2. I would like Dr. Sun or his staff to leave only a message to return their call. I acknowledge that this may delay my receipt of important information.

ATHENA PORTAL ACCOUNT

Our electronic health record allows patients to access their billing information, upcoming appointments, imaging results, laboratory results, and offers a secure means of communication with our providers through portal messages. Please indicate if you would like to set up a portal and if so, provide your personal email address.

_____ 1. No, I prefer not to set up a portal account.

_____ 2. Yes, I would like to set up a portal account.

Personal e-mail address (please print) _____

SECURE EMAIL

We understand that some patients would like to opt out of creating portal accounts, but would still like to provide an email address for practice use which may include sending telehealth video links, appointment reminders, lab orders, or referrals. Significantly abnormal results will still be communicated by telephone. **This is a secure means of communication.** However, please do not provide a work e-mail address, as all company e-mail is usually saved on work computers regardless of whether the message has been erased, and your medical information should not be readily available to your employer. Please check one of the following:

_____ 1. I prefer not to use e-mail for any kind of communication.

_____ 2. I would like to supply an email for Dr. Sun or his staff to contact me by e-mail when applicable.

Personal e-mail address (please print) _____

Signed _____ Date _____

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Name _____ Date of Birth _____

The purpose of this questionnaire is to gather information concerning your health and physical condition, both now and in the past. **This information is confidential.** Please answer all the following questions fully and completely as best as you can. If you don't understand a question, please be sure to mark it so that the provider can review it with you.

Demographics

In what country were you born: _____

Please describe your level of education: _____

Current work status: ☐ Employed ☐ Retired ☐ Disabled ☐ Unemployed

Work history: My principal work (including homemaking) during my life has been:

_____

Relationship status: ☐ Single ☐ In a relationship ☐ Married ☐ Divorced ☐ Widowed

Living arrangement: ☐ Live alone ☐ With partner ☐ With children ☐ With companions

Interests: How do you like to spend your free time? _____

_____

Neuro/Psychologic

Please check if you have had:		None of the Following	☐
Frequent headaches	☐ Yes	Trouble falling or staying asleep	☐ Yes
Numbness in your hands or feet	☐ Yes	A temporary loss of speech or vision	☐ Yes
A stroke	☐ Yes	A brain, nerve or other emotional problem not listed: _____	☐ Yes

Eyes, Ears, Nose & Throat

Please check if you have had:		None of the Following	☐
Blurry or double vision	☐ Yes	Frequent nose bleeds	☐ Yes
A sudden loss of vision	☐ Yes	Mouth, tongue, or jaw problem	☐ Yes
Trouble hearing	☐ Yes	Thyroid disease	☐ Yes
Frequent ear infections	☐ Yes	An eye, ear, nose, or throat problem not listed: _____	☐ Yes

Lungs

Please check if you have had:		None of the Following	☐
Wheezing	☐ Yes	Emphysema	☐ Yes
Shortness of breath	☐ Yes	Tuberculosis	☐ Yes
A chronic cough	☐ Yes	Pulmonary embolism	☐ Yes
Asthma?	☐ Yes	Other lung or chest problem not listed: _____	☐ Yes

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Smoking History

Do you smoke or have you ever smoked? ☐ Yes, current. ☐ Yes, former.

Cardiovascular

Please check if you have had:		None of the following	☐
High blood pressure	☐ Yes	A cholesterol problem	☐ Yes
A heart valve problem	☐ Yes	An abnormal treadmill test	☐ Yes
Congestive heart failure	☐ Yes	A heart attack	☐ Yes
Abnormal clot formation	☐ Yes	Episodes of rapid/irregular heartbeat	☐ Yes
Pain in the legs that forces you to stop walking?	☐ Yes	Pressure or tightness in your chest, with exertion or walking uphill?	☐ Yes
Other: _____	☐ Yes		

Digestive

Please check if you have had:		None of the following	☐
Trouble swallowing	☐ Yes	Indigestion or heartburn	☐ Yes
Recurrent nausea or vomiting	☐ Yes	Recurrent abdominal pain	☐ Yes
An episode of vomiting blood	☐ Yes	Frequent diarrhea or constipation	☐ Yes
Inability to control my bowels	☐ Yes	Esophagitis or esophageal reflux	☐ Yes
Liver trouble	☐ Yes	Other gastrointestinal problem not listed: _____	☐ Yes

I am likely to have some form of alcohol: ☐ Never ☐ Hardly ☐ Less than 3x per week ☐ More than 3x per week ☐ Daily

I sometimes wonder if I drink more than is good for me: ☐ Yes

Was there ever a time you drank 5 or more drinks a day of any kind of alcohol beverage? ☐ Yes

Musculoskeletal

Please check if you have had:		None of the following	☐
Night-time leg cramps	☐ Yes	Pain or stiffness in your joints	☐ Yes
Arthritis	☐ Yes	Osteoporosis	☐ Yes
Lupus	☐ Yes	Other musculoskeletal problem not listed: _____	☐ Yes

Men's Health (answer if applicable)

Please check if you have had:		None of the following	☐
Prostatitis	☐ Yes	A kidney stone	☐ Yes
Problems with urination	☐ Yes	Blood in urine	☐ Yes
Problems getting an erection	☐ Yes	Other urinary, sexual, or problem not listed: _____	☐ Yes

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Women's Health (answer if applicable)

Please check if you have had:		None of the following	☐
A problem with your breasts	☐ Yes	Vaginal itching or discharge	☐ Yes
Pain with intercourse	☐ Yes	Chronic pelvic pain	☐ Yes
Problems with urination	☐ Yes	A kidney stone	☐ Yes
Other problem not listed: _____	☐ Yes		
How many pregnancies have you had? _____		How many births have you had? _____	

Important: The information to these additional questions is **confidential, optional, and helpful for your medical treatment.**

Please check all that apply:

I am:			
A virgin	☐ Yes	Sexually active with a male partner	☐ Yes
Not sexually active in the past year	☐ Yes	Sexually active with a female partner	☐ Yes
Satisfied with my sex life	☐ Yes	Sexually active with > 1 partner	☐ Yes
Possibly at risk for HIV or AIDS	☐ Yes		
I have or have had:			
Chlamydia	☐ Yes	Other STI/STD not listed: _____	☐ Yes

Medication list

Please list any medications you are currently taking, including dosage & frequency.

Medication	**Frequency**	**Prescriber**

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Surgical History

Surgery	Date

Have you ever been diagnosed with any cancers? ☐ No ☐ Yes: _____

Family History

I am:	Adopted: ☐ No ☐ Yes	An identical twin: ☐ No ☐ Yes
	I have _____ full brother(s). I have _____ full sister(s).	I have _____ half-brother(s). I have _____ half-sister(s).

Please check any appropriate boxes. The following have occurred in my family:

	Mother	Father	Brothers	Sisters	Grandparents
Abnormal blood clots					
Alcoholism					
A rare hereditary disease					
Cancer					
Depression					
Diabetes					
Drug abuse					
Heart attack					
High blood pressure					
High cholesterol					
Kidney problems					
Liver problems					
Stroke					
Suicide					
Other serious health or emotional problem					
***If deceased, please write the age in which they died.**					

Miscellaneous: *Is there anything else you believe we should know to aid in your care?*

_____

_____

_____

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Name _____ Date of Birth _____

Privacy Notice
I have read and received a copy of the practice's Privacy Notice.

Signature: _____ Date: _____

Authorization to Release Billing & Medical Information
I hereby authorize the provider to release any billing, medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

Signature: _____ Date: _____

Assignment of Insurance Benefits
I hereby authorize direct payment of surgical/medical benefits to Dr. Sun, for all services rendered by him or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Signature: _____ Date: _____

Financial and No Show/Cancellation Policies
I have read and understand the Practice Financial and No-Show/cancellation policies and I agree to be bound by its terms.

Signature: _____ Date: _____

Telemedicine Consent
I have read and understand the Virtual Visit Consent form and I agree to be bound by its terms.

Signature: _____ Date: _____

Medicare/Medicaid (if applicable)
I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

Signature: _____ Date: _____

A photocopy of these agreements shall be valid as the original.

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Notice of Privacy Practices
Effective Date: September 2022

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition, and related health care services.

Uses And Disclosures of Protected Health Information

Your protected health information (PHI) may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of physicians practice, and any other use required by law.

Treatment: we will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to, in order to ensure that the physician has all necessary information to diagnose or treat you.

Payment: Your PHI will be used, as necessary, to obtain payment for your health care services. For example, obtaining approval for hospital stay may require that your relevant PHI be disclose to the health plan to obtain approval for the hospital admission.

Health care operations: we may use or disclose, as needed, your PHI to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointments.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law; Public Health Issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activities; Military Activity and National Security; Workers' Compensation; Inmates; and Required Uses And Disclosures. Under the law, we must make disclosures to you and when required

by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object, unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means that you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You will then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer. We will not retaliate against you for filing a complaint.

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Practice Policies
Effective Date: September 2022

Medical business transactions can often be confusing. The goal of this document is to try to explain our financial policies in understandable terms, and particularly to cover any points where assumptions might lead to misunderstanding. Please ask as many questions as you wish of our staff to gain the level of understanding you need.

1. Patient is responsible for paying all medical charges. We will bill the insurance company you designate, and you may be confident from experience what your insurance will cover, but in the end you yourself bear the final responsibility for any charges associated with services you request. If the insurance information you provide is incorrect, you are responsible for all charges.

2. Patient agrees to Assignment of Benefits. Your signature indicates that you agree that we will bill your insurance company on your behalf, and that your insurance will make its payments directly to our office for services rendered. If you decline, you will be responsible to pay your entire bill in full at time of service, similar to an uninsured patient, and you will then file a claim with your insurance company on your own.

3. Please plan to present your insurance card and identification at every visit. Office policy is to check that insurance designated by patient is in effect at the time of each visit.

4. Our participation in specific insurance plans may change: Insurance companies may change their payment schedule or other terms, and we may add or subtract to the list of plans we participate in as business conditions change. We intend to inform affected patients as soon as possible of such changes, before they go into effect, but we recognize that such changes may still create a hardship for patients even with advanced notice.

5. Uncertainty of estimate of charges: If you are a self-pay patient, our staff can provide a list of charges before the visit. If you have insurance, please recognize that medical offices may have as much difficulty as the patient in estimating in advance what a specific insurance plan will pay for a specific service.

6. Payments before the visit:

a. Your insurance plan may require a **co-pay**, which is a payment made by the patient at the time of the visit. If so, you will be asked to make this payment online via your portal account or at the office front desk upon check-in.

b. Meeting your insurance **"deductible":** Many insurance policies require that the patient initially make payments in full themselves for healthcare costs until a certain "deductible" level has been met for the policy year. If that is the case, you may be asked to pay for 100% of the contractual cost of the visit until your insurance company has recorded that you have paid up to the deductible limit of your insurance policy, at which point the insurance company will begin to help pay for your medical expenses.

c. **Self-pay:** If you are paying for medical care yourself, without medical insurance, you will be asked to make a payment at the time of service.

7. Patient bills after insurance payment: Once we receive an "Explanation of Benefits" (paper) or an "Electronic Remittance Advice" (electronic) from your insurance, the remaining patient financial obligation will be known. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits.

8. Referral to collections: The practice uses an outside collection service to collect payments more than 90 days overdue. Once referred to collections, the business policies of that separate company will prevail, and may include standard collection processes such as notification of credit agencies and garnishment of wages.

9. Additional charges:

Missed appointments: Per our **No-Show & Cancellation policy**, we request that you please give our office at least 24-hour notice if you need to reschedule your appointment. If you do not provide us with a 24-hour notice, or if you do not show up for a scheduled appointment, **you may be charged a $25 rescheduling fee for office visits and a $75 fee for physical exams.** A patient who is a no-show three times or more may not be rescheduled for future appointments and may be dismissed from the practice. Payment is expected prior to or at the time of your next visit. Our Late Arrival Policy is as follows: If a patient is more than 15 minutes late to their appointment, the appointment may be canceled and need to be rescheduled. Patients arriving late may also be asked to wait to be seen until the provider has an opening in their schedule.

10. We try to provide excellent medical care. We regret we cannot also provide medical business consultation services. The current business of medicine is complex in the United States. Our goal and training background are to provide excellent medical care to you. While we will try to be helpful where we can, often patients have questions about their insurance plan or other medical business matters that we cannot answer without extensive and time-consuming research, for which we are not compensated. **It is primarily your job to understand the terms of your insurance plan** and other medical business matters, or to engage the services of someone who can help.

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Informed Consent for Telemedicine Consultations Effective Date: September 2022

"Telemedicine" means that you may be evaluated and treated by a health care provider from a distant location via electronic communication, which may include videoconferencing, phone calls or portal messages. Since this may be different than the type of consultation with which you are familiar, it is important that you understand and agree to the following statements:

- Telemedicine must be conducted with both the health care provider and the patient in California.

- The consulting health care provider will be at a different location from me. Additional medical or registration personnel may also be present in the room with the provider.

- I understand there are potential risks to this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties, and call termination. I understand there are alternatives and limitations to this type of care. I understand that my health care provider or I can discontinue the telemedicine consultation/visit if it is felt that the videoconferencing connections are not adequate for my situation.

- It is my obligation to notify my health care provider of any persons in the location, either on or off camera, who can hear or see the session. I understand that I am responsible for ensuring privacy at my location, including ensuring that any artificial intelligence devices, such as “Alexa” or “Echo” be disabled or not be in the location where telemedicine takes place.

- I understand that I may be released before all my medical problems are known or treated and it is my responsibility to make such conditions or symptoms known to the medical personnel as well as to plan for follow-up care.

Authorizations

- The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees as follows: I am granting permission to all physicians and any other healthcare professionals to perform and administer care and treatment of the patient, or designated other qualified health care provider for such services.

- Grants permission to release to third party payor(s), Medicare, Medicaid, their representatives and/or physician(s) involved in the patient's care, any information needed in connection with all care rendered to patient.

- If the patient is under the age of 18 or lacks capacity, the signing party affirms that they are either the parent or legal guardian of such patient and has full legal authority to seek medical assistance on behalf of the patient.

Telemedicine Financial Responsibility

I and/or my insurance carrier(s) agree to pay, in a timely manner, for the services provided. If I have Medicare, I understand that I do have coverage for telemedicine, **including phone calls and portal messaging**, but I will still be responsible for any copays or deductibles. If I have commercial insurance, I understand that it is my responsibility to find out if my insurer covers telemedicine visits, and if not, I will be responsible for the payment.