Harry H. Huang, M.D.
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# Annual Medical History Update

_____ M F _____ _____

Patient's Name Sex Date of Birth Today's Date

Primary Care Physician: _____

Current medical conditions

- ❑ Alzheimer's and/or Dementia
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ Cancer Type:_____
- ❑ Cardiovascular Disease
- ❑ Depression
- ❑ Diabetes
- ❑ GERD (gastroesophageal reflux disease)
- ❑ Hyperlipidemia (high cholesterol)
- ❑ Hypertension (high blood pressure)
- ❑ Kidney Disease
- ❑ Lung Diseases (including COPD)
- ❑ Myocardial Infarction
- ❑ Parkinson's Disease
- ❑ Rheumatoid Arthritis
- ❑ Seizures
- ❑ Stroke
- ❑ Thyroid Disorders
- ❑ Other:_____

Surgeries (systemic and ocular) and/or recent hospitalizations: _____

_____

Medications (name & dosage):

_____

_____

_____

Do you have any drug allergies? NO YES: _____

Do you or did you smoke tobacco? NO YES QUIT: _____

Do you drink alcohol? NO YES

Family History: Please list any medical and/or ocular diseases that any immediate family member has been diagnosed and/or treated for.

_____

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## Insurance Participation

The Office of Harry H Huang, MD, PA is a Participating Provider with the following insurance companies ONLY:

1. **Medicare (Standard and Railroad Retirement Medicare only)**
2. **Carefirst/Blue Cross Blue Shield of the National Capital Area (PPO and Federal plans only – WE DO NOT PARTICIPATE WITH BLUE CHOICE)**
3. **Cigna (PPO and Open Access Plus)**

This office is **NOT** a Participating Provider with any HMO plans (including Blue Choice- the Carefirst HMO - or any Medicare HMO Plans), with any Vision/Optical Plans, with Medicaid or with **ANY** other commercial carriers, including Aetna, Cigna HMO, Kaiser, and United Healthcare. If you have straight HMO coverage, or do not have out-of-network benefits, you will NOT be reimbursed for any services provided by this office.

If we do not participate with your insurance but your plan has out-of-network benefits, your services may potentially be covered – all or in part – after you have satisfied any calendar deductible. We will submit these claims for you, but any co-pay is due at the time of your visit and you will be responsible for the full amount of the entire balance (including any non-covered charges) without adjustment, after the claim is processed. If you have an HMO plan or have no out-of-network benefits, you will be responsible for payment of all charges at the time of your visit and we will submit your claim only upon request. Please be advised that we do not assume responsibility for obtaining referrals and pre-authorizations that may be required by your plan. You must obtain these yourself prior to your visit. In addition, in certain limited cases if Medicare is your secondary insurance and the primary carrier is an HMO, Medicare may not cover your charges, leaving you responsible for the entire charged amount. If you have any questions about your insurance, please be sure to inquire with our staff prior to the time that you are seen.

## Refraction Charge:

Every new patient, patients returning for routine exams, patients needing a new glasses prescription, contact lens wearers, and patients following cataract surgery, should expect to have a refraction done. This is often necessary to determine whether any medical, optical or surgical treatment may be indicated. The fee for a refraction is $45. Most major insurance companies including Medicare **DO NOT** cover the cost of a refraction regardless of the reason it is performed. We do NOT participate in any Vision Plans through any insurance carriers that may cover this refraction charge and do NOT submit claims to any Vision Plans.

## Insurance Authorization and Assignment of Benefits:

I understand and agree to the above policies regarding insurance participation and the charge for refractions. I request that payment of authorized Medicare/Other Insurance company benefits be made on my behalf to Harry H Huang, MD, PA for any services furnished to me by Harry H Huang, MD. I authorize the holder of medical information about me to release any information needed to determine the benefits payable for related services to Medicare and the Health Care Financing Administration and its agents to or my Insurance Company.

## Privacy Policy:

The office's HIPAA privacy policy is posted and a copy is available for review. It contains important information regarding the use and disclosure of your healthcare information.

*I have been notified of the office policy regarding the use and disclosure of my health information.*

Print Patient Name: _____ Date: _____

Patient (or Guardian) Signature: _____