Danny L. Huynh, M.D.
Urology

2120 Truxtun Ave.
Bakersfield, CA 93301
Phone: 661-327-3638 Fax: 661-327-2869

Thank you for choosing us as your Healthcare Provider. Enclosed you will find a packet of information that will need to be carefully read, filled out and brought to your appointment.

IMPORTANT - PLEASE READ:

1. **ALL PAGES** of this packed **MUST BE FILLED OUT** out front and back before you come to the office for your appointment. Bring the filled out packet with you to your appointment.
2. Bring a **LIST OF MEDICATION** and any questions you might have for Dr. Huynh. This will allow Dr. Huynh to address them on the day of your appointment.
3. Be prepared to present **INSURANCE CARD, DRIVER'S LICENSE** and **NECESSARY PAYMENT** for the date of service.
4. Please note that if you are **MORE THAN 15 MINUTES LATE**, you will need to **RESCHEDULE**.
5. **Urine sample will be requested upon arrival.**

We look forward to seeing you and making your visit a pleasant one.

Sincerely,

The Staff at Danny L. Huynh, M.D. Urology

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Patient Registration Information

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Patient Information

Name: _____ Age: _____

DOB: _____ SS#: _____ DL # _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female

Home Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Cell Phone: _____ Email address: _____

Mailing Address (If different from above): _____

City: _____ State: _____ Zip: _____

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Hispanic/Latino ☐ Other _____

Ethnicity: ☐ Hispanic / Latino ☐ NOT Hispanic / Latino

Language: ☐ English ☐ Spanish ☐ Other _____

Employment Status: ☐ Employed ☐ Retired ☐ Unemployed ☐ Other _____

Occupation: _____ Employers Phone: _____

Do you have an “Advanced Directive”, also known as a “Living Will” or a “Durable Power of Attorney for Health Care”? ☐ Yes ☐ No (If yes, please provide a copy for your medical record)

PCP: _____ Office #: _____ Fax #: _____

Preferred Pharmacy: _____ Address: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

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Spouse Information

Name: _____ Date of Birth: _____

Home Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ SS#: _____

Employment Status: □ Employed □ Retired □ Unemployed □ Other _____

Employer: _____ Employers Phone: _____

Emergency Information

Provide information on the nearest adult relative, not your spouse, who is NOT living with you.

Name: _____ Relationship: _____

Home Address: _____City: _____

State: _____ Zip: _____ Phone: _____

Insurance Information

Please present your insurance ID card to our receptionist. We will scan a copy of your ID card for your convenience.

Financial Policy

I will be responsible for notifying the office of Dr. Danny L. Huynh, M.D. of any specific laboratory, x-ray, hospital facility required by my insurance. I am also responsible for obtaining authorization from my insurance company to see Dr. Danny L. Huynh should it be required. I authorize payment for all services rendered by paid directly to Dr. Danny L. Huynh. I understand I am responsible for payment of services rendered.

Signature _____ Date _____

*The above information is true and correct to the best of my knowledge

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Forms Completion Fee Schedule

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On occasion forms are presented to the office to be completed for school, camp, employment physicals, disability, AFLAC, etc. Due to the time required to complete the forms, we have to charge for this additional service.

Form Fee: $25.00

Forms will be completed 10 days from the date requested unless otherwise noted.

Copying of Medical Records Fee Schedule:

Pages 1-20 Cost up to $1.30/page
Pages 21-60 Cost up to $0.99/page
Pages 61+ Cost up to $0.33/page

Cancellation/No Show Policy

A $25 cancellation fee will apply for any appointments not cancelled within 24 hours of appointment time. $50 cancellation fee will apply for any procedure not cancelled within 24 hours of appointment time. $100 cancellation fee will apply for any surgery not cancelled within 24 hours of surgery date.

Please sign below to indicate that you have read and agree with the fees.

_____ _____

Patient / Guardian Signature Date

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Appointment Reminder Consent

Patient Name: _____

I HEREBY AUTHORIZE the offices of Danny L. Huynh, M.D. to call me prior to an appointment to remind me of the date and time. I give consent to receive automated reminder text/voice messages to my main number on file.

Please provide preferred number:

□ Home Number _____

□ Cell Number _____

Standard text message fees may apply

I understand that, regardless of whether I give my consent for an appointment reminder, I am expected to arrive in a timely manner for my appointment and that I may be responsible for payment of the cancelled appointment fee of $25 ($50 for a procedure) if I do not provide 24 hours notice of cancellation of my scheduled appointment. I further understand that I may withdraw this consent at any time, either verbally or in writing. This consent will last until I withdraw my consent.

Patient Name (Print)_____

Signature: _____ Date: _____
Patient//guardian/conservator

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Authorization to Allow Access to Medical Information

Patient Information:

Name: _____

Birthdate: _____ Age: _____

SSN#: _____ Phone #: _____

If you do not wish to authorize access of your medical information to anyone, initial here: _____

Provide My Medical Information Upon Request To:

Name	Date of Birth	Phone Number	Relationship to Patient

The information that I request includes all medical records, billing records and all phone calls regarding the patient's care in our office.

I authorize the release of information as described above from Dr. Danny L. Huynh, M.D. This authorization will not expire and must be revoked by me. I can revoke it or change it at any time by signing a new authorization form. I understand that the information I authorize to be released may be subject to re-disclosure by the recipient.

_____ _____

Patient or Guardian Signature Date

Relationship to Patient: _____

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ACKNOWLEDGEMENT OF RECEIVING NOTICE OF PRIVACY PRACTICE

Our notice of privacy practice provides detailed information about how we may use and disclose protected health information about you. You have the right to read this notice and have a copy of the notice and we reserve the right to change the notice. You can obtain this information at the office of Danny L. Huynh, M.D.

PATIENT PRINTED NAME:
_____

PATIENT SIGNATURE: _____ DATE
_____