TRIBECA RADIATION

Patient Registration
住院登记表

Last Name 姓:_____ First Name 名: _____

Date of Birth 出生日期:_____/_____/_____ Age 年龄:_____

Address 住址: _____
Street 街道 City 城 State 州 ZIP 邮

☐ Male 男 ☐ Female 女 Marital Status 婚姻状况 (Circle 范围): S 未婚 M 已婚 D 离 W 丧偶

SS#: _____
Optional 选填

Home Phone 家庭电话: _____ Mobile Phone 移动电话: _____

Name of referring doctor 顾问医师: _____Phone 电话: _____

Name of primary care doctor 初级保健医师: _____Phone 电话: _____

Attention: We will use the address above and all phone numbers and address listed to contact you, mail copy of office visit notes and/or leave messages, and speak to friends or family involved in your care. Please see the Office Manager if you wish to place a restriction on the use of this information for these purposes.
注意：我们将通过以上联系方式与您联系，向您发送探访记录邮件复件或给您留言，以及与护理您的朋友或家人进行交流。对此如有异议，请联系办公室经理。

Are you a patient in a skilled nursing home? 你是否在专业疗养院进行过疗养？ ☐ Yes 是 ☐ No 否
If yes, where: 如果曾经有的话，疗养院的名称:_____

Employed 工作与否: ☐ Yes 是 ☐ No 否 Employer Name 工作单位: _____
Occupation 职业: _____

Race 种族: ☐ American Indian or Alaskan Native 美洲印第安人或阿拉斯加土著居民 ☐ Asian 亚洲人
☐ Black or African American 黑人或非裔美国人 ☐ White 白人
☐ Native Hawaiian or other Pacific Islander 夏威夷土著居民或其他太平洋岛民 ☐ Decline to Answer 拒绝回答

Ethnicity 种族: ☐ Hispanic or Latino 西班牙裔或拉丁裔 ☐ Not Hispanic or Latino 非西班牙裔或拉丁
☐ Decline to Answer 拒绝回答

Spoken Language 语言: _____Preferred Language 首选语言: _____

Emergency Contact 紧急联络人: _____ Relationship 关系: _____Phone 电话: _____

TRIBECA RADIATION

Person responsible for payment if other than patient 除患者之外，担保人将负责支付医疗款项。

Guarantor Name 担保人姓名: _____Relationship to Patient 与患者的关系: _____
Address 住址: _____Phone 电话: _____

Primary Insurance Information
首要保险信息

Name of Insurance 保险机构名称: _____Subscriber 参保人: _____
DOB 出生日期: _____/_____/_____
Member ID# 会员证号: _____Group # 小组:_____Effective Date 生效日期:_____

Secondary Insurance Information
级保险信息

Name of Insurance 保险机构名称: _____Subscriber 参保人: _____
DOB 出生日期: _____/_____/_____
Member ID# 会员证号: _____Group # 小组:_____Effective Date 生效日期:_____

_____ _____
Signature of patient or representative 患者或代理人签字 Date 日期

TRIBECA RADIATION

General Assignment of Benefits
保险权益一般转让

I request that payment of authorized insurance benefits be made on my behalf to the Provider for any equipment or services provided to me by those organizations. I authorize the release of any medical or other information to my insurance company in order to determine the benefits payable for the services rendered by the Provider.
我请求，就这些组织提供给我的设备或服务，以我的名义将核准的保险赔偿金支付给提供者。我授权将任何医疗或其他信息向保险公司公开以确定支付提供者所提供服务的保险金额。
I understand that I am financially responsible to the Provider for any charges not covered by my health benefits. It is my responsibility to notify the Provider of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill if the submitted claims or any part of them are denied for payment. I accept financial responsibility for payment for all services or products received.
我明白，我应对保险范围之外的费用为提供者承担经济责任。将医疗保险所有费用通知给提供者是我的责任所在。有些情况下，保险金额直至保险公司收到索赔要求后方能确定。如果所提交的索赔请求或任何索赔部分被拒付，我负责支付整个账单或账单余额。我负责对所有接受的服务或产品服务承担经济责任。

_____ _____

Patient/Guardian Signature 患者/监护人签名: Date 日期:

Receipt of Notice of HIPAA Privacy Practices
收到 HIPAA 保密措施通知

I have received the Notice of Privacy Practice from the Provider
我收到提供者的保密措施通知

_____ _____

Patient/Guardian Signature 患者/监护人签名: Date 日期:

TRIBECA RADIATION

Medicare Lifetime Assignment of Benefits
医疗终生保险利益转让

I request that payment of authorized Medicare benefits be made to me or on my behalf to _____ (the "Provider") for any services furnished me by the Provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.
我请求，就我接受的提供方的所有服务，核准的医疗保险金需支付给我本人或代表我的_____（"提供者"）。我授权任何掌握我医疗信息的所有人向中心公开医疗保险和医疗补助服务，并且在其代理需要相关信息来确定保险金或支付给相关服务的保险金时可以向代理公开此部分信息。

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier. This assignment is effective until evoked by me in writing.
在指定医疗保险的情况下，医师或服务提供方同意医保主联络人确定的费用作为所有费用，患者对可抵扣的、共同保险和未投保的服务承担费用。共同保险和免赔额以医保主联络人确定的费用为基础计算。本保险转让至我以书面确定终止时方无效。

_____ _____
Patient/Guardian Signature 患者/监护人签名: Date 日期:

Medi-gap (Medicare supplemental insurance) Assignment of Benefits
Medi-gap （补充医疗保险）利益转让

I request payment of authorized Medi-gap benefits be made to the Provider and also authorize any holder of medical information about me to release to the Medi-gap insurer listed below any information needed to determine benefits payable for services from the Provider. This assignment is effective until evoked by me in writing.
我请求，核准的 Medi-gap 保险金需支付给提供者，同时授权任何掌握我医疗信息的所有人向下方所列 Medi-gap 承保人公开所有用来确定支付给提供者服务保险金的信息。本保险转让至我以书面确定终止时方无效。

Medi-gap Insurance Name Medi-gap 保险名称: _____

_____ _____
Patient/Guardian Signature 患者/监护人签名: Date 日期:

TRIBECA RADIATION

AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS
授权获得/公开医疗记录

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R Parts 160 and 164)
（应健康保险隐私和责任法案，45 C.F.R 160 和 164 部分要求）

I authorize _____x_____any and all medical entities_____ (healthcare provider)_____ to release my medical records to the following individual or entity:
我授权任何 _____ 和所有医疗单位 _____(保健服务提供者)_____来向下列个人或单位公开我的医疗记录：

Individual or Entity 个人或单位: _____

Patient Name 患者姓名: _____ Date of Birth 出生日期: _____/_____/_____

Address 住址: _____

City 城市: _____ State 州: _____ Zip 邮编_____

This authorization for release of information covers the period of healthcare:
本信息公开授权涵盖医疗服务的整个时期：

From: _____ To _____ ***OR*** all past, present, and future periods.
从：_____ 到 _____ 或 所有过去、现在和未来的医疗时期。

☐ I authorize the release of my complete health records (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
我授权公开我的完整医疗记录（包括与心理保健、传染病、艾滋病病毒感染或艾滋病有关的记录和酒精或药物滥用治疗记录）。

OR 或

☐ I authorize the release of my complete health record with the exception of the following information:
我授权公开的完整健康记录不包括如下信息：

- ☐ Mental health records 心理健康记录
- ☐ Communicable diseases (including HIV and AIDS) 传染病 （包括艾滋病病毒感染和艾滋病）
- ☐ Alcohol/drug abuse treatment 酒精/药物滥用治疗
- ☐ Other (please specify): _____ 其他 （请注明）：_____

The purpose of this release 信息公开的目的: _____

This medical information may used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
我授权接受此类医疗信息的人可将其用于医疗或咨询、开账单或索赔付款或我列出的其他目的。

This authorization shall be in force and effective for one year (365 days) from the date of my signature below.
本授权自我下方签字之日起 365 天内有效。

TRIBECA RADIATION

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim.
我明白，我有权随时以书面形式撤销此授权。我明白，如果任何个人或单位已经根据我授权实施的部分，或者如果获得授权是纳入保险范围的条件，承保人据此才有同意索赔的合法权利，那撤销对实施部分无效。

I understand that my treatment, payment, enrollment, or eligibility for benefits will not conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
我明白，我治疗、支付、注册或领取保险金的资格并不取决于我是否在本授权签字。我明白，根据本授权所用或已公开信息可能会被接受者再次公开，可能不会再受到联邦或州法律的保护。

_____ _____

Signature of patient or personal representative
患者或授权代表签名

Date 日期

_____ _____

Printed name of patient or personal representative
患者或授权代表印刷体姓名

Relationship to the patient
与患者关系

E-MAIL CONSENT FORM 电子邮件知情同意书

_____

Patient's Name Printed 打印版患者姓名

_____

Patient's Address 患者住址

_____ _____

Patient's E-mail Address 患者电子邮箱地址 **Patient's Phone Number** 患者电话号码

DO NOT USE EMAIL FOR EMERGENCY, URGENT & SENSITIVE PROBLEMS!
对于突发事件、紧急情况以及敏感问题，请勿使用电子邮件。

E-mail should never be used for emergency or urgent problems. For a life-threatening emergency, call 911. For urgent or sensitive problems, call the office at 212-925-8882. We recommend office visits for all new, complex or sensitive problems. When we are not in the office, the answering message will direct you to an on-call doctor who can give advice or direct you to a source of emergency or urgent care.
针对突发情况或紧急问题，请勿使用电子邮件。危及生命的紧急情况，请拨打911。紧急或敏感问题，请拨打办公室电话 212-925-8882。针对所有新出现的、复杂的或敏感的问题，我们会安排专职人员进行走访。若办公室无人，电话答录机会将语音留言转接给值班医生。值班医生将给您建议或直接指导您进行紧急护理。

1. RISKS OF USING E-MAILTO COMMUNICATE WITH YOUR PROVIDER
使用电子邮件与医疗服务机构交流的风险

The term "Provider" in this consent refers to Dr. J.P. Tracy Ng, M.D. and the staff. The Providers offer patients the opportunity to communicate by e-mail. However, transmitting patient information by e-mail has risks that patients should consider. Risks include, but are not limited to:
术语"医疗服务机构"在此指的是医学博士 J.P. Tracy Ng 以及全体职员。医疗服务机构给患者提供通过电子邮件交流的机会。然而，患者需要注意：通过电子邮件传递患者信息具有风险性。其中包含但不限于：

- E-mail can be circulated, forwarded, and stored in paper and electronic files.
- 和电子档案的形式进行传阅、转发及储存。
- E-mail can be broadcast worldwide or can be received by unintended recipients at home or at work.
- 电子邮件能在全球范围内广为传播或者被未指定收件方在家中或工作中接收。
- E-mail senders can accidentally type the wrong email address or send to others besides the intended recipient.
- 电子邮件发送人可能会不小心输入错误的电子邮件地址或发送给除指定收件人之外的其他人。
- E-mail is easier to falsify than handwritten or signed documents.
- 电子邮件比手写或签署的文件更易于伪造。
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
- 即使在发送人或接收人已经删除复件之后，电子邮件的备份可能仍然存在。
- Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
- 工作人员和在线服务有权存档并检查经由他们系统所传输的电子邮件。
- E-mail can be used as evidence in court.
- 电子邮件可用作庭审证据。

- E-mail can introduce viruses or worms into computer systems.
  电子邮件可能给计算机系统带来病毒或蠕虫。

2. CONDITIONS FOR THE USE OF E-MAIL
电子邮件使用条件

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, patients must give signed consent to the use of patient information in e-mail, indicating agreement with these conditions:
医疗服务机构将采用合理的方式保护收发邮件信息的安全性和保密性。然而，医疗服务机构不能保证电子邮件交流的安全性和保密性。对于非因医疗服务机构蓄意而导致的机密信息泄露，医疗服务机构将概不负责。因此，有关在电子邮件中使用患者信息的行为，患者需要签署同意书，表明同意以下条件：

- All e-mails to or from the patient concerning treatment will be added to the patient's medical record. Therefore, other individuals authorized to access the medical record will have access to those e-mails.
- 所有由患者收发的有关治疗的电子邮件将被添加到患者的病例中。因此，经授权可以获取病例的个人，同样可以获取这些电子邮件。
- Provider may forward e-mails internally to Provider's staff as necessary for treatment, payment, and operations. Provider will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
- 为便于治疗、付款和操作，医疗服务机构可以在必要的时候向其职员转发电子邮件。但是，未经患者事先书面同意，医疗服务机构不能将电子邮件转发至独立的第三方，法律授权或规定的除外。
- Provider or staff shall confirm when an e-mail from the patient has been received and read. However, the patient shall not use e-mail for medical emergencies, urgent problems or other time sensitive matters.
- 当已经接收并阅读完来自患者的电子邮件后，医疗服务机构或职员应当进行确认。但是，对于突发事件、紧急问题或其他时间敏感问题，患者不应使用电子邮件。
- If the patient's e-mail requires or requests a response from Provider, and the patient has not received a response within 3 days, the patient is responsible to follow up to determine whether the intended recipient received the e-mail and when he/she will respond.
- 若患者要求医疗机构做出回复，且三天内未收到回复，患者有责任跟进并确定该邮件接收者是否收到以及他/她做出回复的时间。
- The patient should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- 涉及到敏感医疗信息，如性传播疾病、AIDS/HIV、心理健康、发育性残疾或药物滥用，患者不应使用电子邮件进行交流。
- The patient is responsible for informing Provider of any other types of information the patient does not want to be sent by e-mail.
- 患者有责任告知医疗服务机构其不想用电子邮件发送的所有其他类型的信息。
- The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
- 患者有责任保护好自己的邮箱密码或使用方式。由患者或第三方造成的信息泄露，医疗服务机构概不负责。
- Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines or treating patients who have not first been seen in the office.
- 患者不应进行非法电子邮件交流，如，跨州非法行医或治疗从未前来就医的患者。
- It is the patient's responsibility to follow up and/or schedule an appointment if warranted.
- 如果必要的话，患者有责跟进并预约挂号。

TRIBECA RADIATION

3. PATIENT RESPONSIBILITIES AND INSTRUCTIONS
患者责任和说明

To communicate by e-mail, the patient shall:
通过电子邮件进行交流，患者应当：

- Limit or avoid use of his/her employer's computer.
- 避免或有限的使用雇主的电脑。
- Inform Provider of changes in his/her email address.
- 如若变更邮箱，请告知医疗服务机构。
- Confirm that he/she has received and read an e-mail from the Provider.
- 确保已接收并阅读了来自医疗服务机构的电子邮件。
- Put the patient's name in the body of the e-mail.
- 将姓名写入电子邮件的正文中。
- Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing question).
- 把信息类别包含在邮件的主题里以便分门别类(例如账单问题)
- Review the e-mail to make sure it is clear and that all relevant information if provided before sending to Provider.
- 将电子邮件发送至医疗服务机构之前，对其进行检查以确保其条理清晰并涵盖所有相关信息。
- Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.
- 采取措施保护电子邮件机密，如：使用屏幕保护程序、电脑密码。
- Withdraw consent only by e-mail or written communication to Provider.
- 与医疗服务机构通过电子邮件或书面形式进行交流，撤销同意。
- E-mail should be brief, and to the point.
  电子邮件应当简洁、扼要。

4. ALTERNATE FORMS OF COMMUNICATION
交流的可选方式

I understand that I may also communicate with the Provider via telephone or during a scheduled appointment and that e-mail is not a substitute for the care that may be provided during an office visit. If no response from email is received after 3 days, the patient should call the office.
我认为我可以通过电话或预约会面与医疗服务机构进行交流，电子邮件不能代替在寻医就诊期间提供的护理。如果三天内未收到回复，患者应致电办公室。

5. TYPES OF E-MAIL TRANSMISSIONS THAT PATIENT AGREES TO SEND AND/OR RECEIVE
患者同意收发邮件的方式

Types of information that can be communicated via e-mail with the Provider include prescription refills, referral requests, appointment scheduling requests, billing and insurance questions, patient education, and clinical consultation. If you are not sure if the issue you wish to discuss should be included in an e-mail, please call Provider's office to schedule an appointment.
可经由电子邮件与医疗服务机构进行交流的信息类型包括：按处方续配、转诊请求、预约安排请求、计费和保险问题、患者宣教和临床会诊。若您不放心您希望商讨的问题是否已经写进了邮件，请致电医疗服务机构办公室进行预约安排。

TRIBECA RADIATION

6. HOLD HARMLESS
免受损协定

I agree to indemnify and hold harmless the Provider, its employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider or to use Provider's Web Site (tribecaradiation.com), any arrangements made based on information obtained at the Site, any products or services obtained through the Site, and any breach by me of these restrictions and conditions. The Provider does not warrant that the functions contained in any materials provided will be uninterrupted or error-free, that defects will be corrected, or that the Provider's Site or the server that makes the Site available is free of viruses or other harmful components.
我同意赔偿，使医疗服务机构、新世纪癌症治疗中心、员工、代理人、信息供应者、网站设计师和维护师免受所有损失、花费、损害赔偿及费用，包括：合理律师费、由于技术问题而导致的与信息有关的损失或由信息导致的损失、我使用因特网与医疗服务机构进行交流或使用医疗服务机构网址（tribecaradiation.com）的费用、基于网站上所获信息预约的费用、通过网站获得的产品或服务的费用以及我违背的约束和条件的赔偿费用。医疗服务机构不能保证提供的材料中所包含的内容完全或无误、无缺陷、医疗服务机构的网站或进入网站所需的服务器无病毒或其他有害组件。

7. TERMINATION OF THE E-MAIL RELATIONSHIP
关联电子邮件的终止

Provider has the right to immediately terminate the e-mail relationship with a patient if he/she determines, in his/her sole discretion, that patient has violated the terms and conditions set forth above or otherwise breached this agreement, or has engaged in conduct which the Provider determines, in his/her sole discretion, to be unacceptable. The e-mail relationship between the Provider and the patient will terminate in the event the Provider, in his/her sole discretion, no longer wishes to utilize the e-mail to communicate with all of his/her patients. Patient also has the right to terminate the email relationship by written notice to Provider, at any time.
若医疗服务机构人员认为患者违反了上述条款、条件或协议，或患者从事了医疗服务机构自行认为不能接受的行为，医疗服务机构有权立即终止与患者进行电子邮件联系。若医疗服务机构自行决定不再使用电子邮件与患者进行交流，医疗服务机构与患者可终止电子邮件联系。患者同样有权在任何时间通过书面通知医疗服务机构终止电子邮件联系。

PATIENT ACKNOWLEDGEMENT AND AGREEMENT
患者声明与协议

I acknowledge that I have read and fully understand this consent form and discussed it with the Provider or his/her representative. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by e-mail. Any questions I had were answered.
本人声明，我已经阅读并完全理解同意书并与医疗服务机构或其代表进行了讨论。我知晓通过电子邮件与医疗服务机构进行交流的风险，并同意本条款。此外，我同意所罗列的说明及与医疗服务机构进行电子邮件联系中可能出现的其他说明。所有问题已解答完毕。

Patient 患者_____Date 日期_____

Witness 证人_____Date 日期_____