Bonnie Huang Hall, MD PhD
46923 Warm Springs Blvd., Suite 207
Fremont, CA 94539

Consent for treatment: I voluntarily consent to care and treatment performed by Dr. Bonnie Huang Hall or her staff. These may include consultations, diagnostic procedures, medical treatment, or other health care services. The practice of medicine and surgery is not an exact science and that diagnosis and treatment may cause injury or the remote possibility of death. I understand that I have a right to refuse any treatments.

Authorization for release of information: I authorize Dr. Bonnie Huang Hall or her staff to utilize confidential medical information contained in my medical record as necessary for claims payment, medical management, or quality of care review purposes. I have received a copy of the Privacy Practices. Please see Privacy Practices for complete information on how your health information will be used.

Payment agreement: Payment for services is expected at the time of service. I agree to be financially responsible for my share of healthcare costs. There are late cancellation fees for appointments. Credit card information may be obtained to pay for outstanding charges or fees. I have received a copy of the office policies which detail payment policies. I agree to comply with office policies.

I have read this form and by signing it, I understand and agree to what it says. The consent will be effective until mutually agreed upon to change in writing.

NOTICE TO CONSUMERS
Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

_____ Date _____
Patient signature (or parent/guardian)

_____
Printed name

Bonnie Huang Hall, MD PHD

New Patient Contact Information

Legal Name: _____

DOB: _____

Address: (in case I need to mail you information about your health)
_____City/Zip_____

Email address (for sending you receipts/paperwork)
_____

Phone: (for calling you about your health) _____

Please initial
I allow Dr. Hall to leave personal medical information on my phone: [ ] Yes____ [ ] No ___
I allow Dr. Hall to mail me medical information: [ ] Yes____ [ ] No____
Who can I discuss personal medical information with?
[ ] Myself only _____
[ ] Myself and other people listed below: ____
(Name, relationship, and Phone number)
_____

_____

Signature _____ Date _____

OPTIONAL

[ ] I would like to communicate my private medical information using ordinary email with Dr. Hall. This is a convenient method of communication, but I understand that email is not an absolutely private means of communication and may include (but not limited to) risks such as hacking, blackmailing, etc. I understand that if I no longer wish to continue, I must in writing confirm that I no longer wish to continue communicating my medical information via email.

NAME DOB Date:

Past Medical History:
[ ] Diabetes
[ ] Blood Pressure
[ ] Cholesterol

Past Surgical History:
[ ] None
[ ] Appendix removed
[ ] Gallbladder removed

Medications:

Family Medical Problems: [ ]Heart attack [ ] Cancer [ ] Stroke

Allergies: [ ] None _____

Alcohol
Smoking
Drugs

Employment:

Preferred Pharmacy Name, Location, and Phone number :