James H. Lin, M.D.
Nhung Hoang, PA-C
Pediatrics and Adolescent Medicine
www.DuluthChildrensMed.com

3500 Duluth Park Lane, Suite 220
Duluth, GA 30096-3230
(678) 878-2808 (P) • (678) 878-2805 (F)

PATIENT INFORMATION PROFILE

Patient Name _____ Date of Birth _____ Sex _____

Patient Name _____ Date of Birth _____ Sex _____

Patient Name _____ Date of Birth _____ Sex _____

Address _____ Home # _____

_____ Cell # _____

Email _____ Send reminders via: email __ phone _____

Patient Father's Name _____ DOB _____

Address _____ Phone _____

Patient Mother's Name _____ DOB_____

Address _____Phone _____

Is both parents legally responsible for child? __Yes ___No (**if not please provide court documents**)

Emergency Contact (not living with you) _____

Cell # _____

Parent/Guardian who is financially responsible for child's account balance _____

Do you have insurance? _____ Yes _____ No. ***If yes, please provide a current copy of your card***

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION. I hereby authorize this practice to furnish any medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment of my care.

ASSIGNMENT OF BENEFITS. I hereby authorize payment directly to this practice of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the charges for these services. I understand that I am financially responsible for charges not covered by this assignment.

GUARANTEE OF ACCOUNT. I understand that I am financially responsible for all charges for service rendered to my child/children, including the balance remaining after payment of insurance benefits.

_____ _____

Parent/Legal Guardian Signature Date

Print Name and Relationship to Patient: _____

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Financial/Insurance Policy

1. All fees for self-pay patients are due at the time of service. Testing and/or vaccine are subject to additional fees.
2. Our office will verify insurance prior to visits. We will file and insurance claim with your insurer, however, **verification of coverage is not a guarantee of payment**.
3. DCM is contractually obligated by your insurance company to collect your copayments, deductibles, and co insurances.
4. Any services not covered by your plan will be the parent/guardian's responsibility.
5. Full payment of uncovered services by insurance is due within 60 days of the date of service. After 60 days, **balances must be paid in full or financial arrangements must be made before any future appointments will be scheduled**. If arrangements have not been made after 120 days, the account may be transferred to a collection agency.
6. All insurance plan and cards must be presented on the day of service and it must reflect current insurance plan.
7. If a child has more than one insurance plan **ALL plans must be provided** or the parent/guardian's may be held financially responsible for services provided.
8. We do NOT file insurance for problems related to motor vehicle accidents or workman's compensation.
9. Returned checks will result in a $35 fee and your account will be a cash only payment basis.

I have read and understand the financial/insurance policies stated above and agree to accept the responsibility as described above.

_____ _____

Parent/Legal Guardian Signature Date

_____

Patient's Name(s)

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Appointment Policy

1. We require 24 hours' notice for cancellation or rescheduling of all appointments. Failure to do so will result in a **$25 fee** which is NOT covered by insurances.
2. Reminder calls, emails, and texts are a courtesy provided by the office. Cancellation/no show fees are applicable even if a reminder is not received.
3. Rescheduling an appointment on the day of the visit will be subject to a $25 fee.
4. Patients who are late may be subject to a **$15 late fee**. Patients will ONLY be worked back into the provider's schedule if there is allocated time available. **Please call the office if you will be late for your appointment**.
5. Walk in patients will be scheduled for the **next available** opening and wait time will vary base on how busy we are in the office.
6. Add on patients (e.g. unscheduled patients whose parents request at the time of arrival that they be seen) will be seen by the provider when there is an available appointment.

Office Form Policy

DCM requires for any patient requesting forms to have an up-to-date wellness visit with in the year, otherwise an appointment will be required.

1. Form request can take up to 24 to 48 business hours to be completed.
2. We will only email and or send forms to email on file as that is the only email authorized for us to provide sensitive information.
3. ONLY guardians/parents will be given forms as is against HIPAA to provide forms or medical information to unauthorized individuals. You may request a HIPAA form to give authorizations for other individuals to request medical information such as forms.
4. A form fee of $10 is required for certain forms such as preops, disability forms, FMLA, etc. If forms need to be notarized it will be subject to additional fees.
5. Patients will be provided school forms as a one-time curtesy a year. However, can be subject a fee if needed multiple times per year.
6. Copies of full medical records will be provided at a $25 fee per chart.

I have read and understand the appointment and office form policies stated above and agree to accept the responsibility as described above.

_____ _____

Parent/Legal Guardian Signature Date

_____

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Prescription Refill Policy

1. Routine Prescriptions will be refilled ONLY during our regular office hours.
2. Please allow **24 to 48 hours to refill** any routine prescription refills.
3. Please be prepared to provide the medication name, strength (e.g. milligrams), amount, and timing. Also please provide the pharmacy information (phone number and location).
4. Please allow a **minimum of 3 days** for refill request of **special prescriptions** (e.g. stimulant medications for ADHD).
5. It is illegal for physicians to call in prescriptions in states where they are not licensed. Therefore, prescriptions will only be called into local pharmacies which then may have the discretion to transfer the prescription per their own policies.

I have read and understand the prescription refill policies stated above and agree to accept the responsibility as described above.

_____ _____

Parent/Legal Guardian Signature Date

_____

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Patient Consent for Use and Disclosure of Protected Health Information (PHI)

With my consent, Duluth Children's Medicine, PC (DCM) may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Refer to DCM's Notice of Privacy Practices for a more complete description. I have a right to review the Notice of Privacy Practices prior to signing this consent. DCM reserves the right to revise its Notice of Privacy Practices at any time. A copy of a revised Notice of Privacy Practices may be obtained by sending a request to DPL at 3500 Duluth Park Ln, Ste 220, Duluth, GA 30096.

With my consent, DCM may call and or email to the information provided in reference to any items that assist in carrying out TPO, such as appointment reminders, insurance items, and anything pertaining to clinical care.

With my consent, DCM may mail to my home any items that assist the practice in carrying out TPO, such as patient statements.

I have the right to request that DCM restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions. If it does, it is bound by this agreement. By signing this form, I am consenting to DCM use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures based on my prior consent. If I do not sign this consent, DCM may decline to provide treatment to me and my family.

_____ _____

Parent/Legal Guardian Signature Date

_____

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HIPAA Authorization Form

I, _____ (parent/guardian full name), authorize Duluth Children's medicine (DCM) to share my child's protected health information with the following individuals who may be involved in my child's care. I understand that I am responsible for notifying DCM of any changes.

This HIPAA Authorization Form pertains to the following children:

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Disclosure of medical information

The name(s) listed below are family member(s) or friends to whom I grant permission for DCM representatives to verbally discuss my child's care using their best judgment and grant them permission to **disclose medical information** that is relevant to my child's care such as appointment changes, billing information and/or needed treatment:

Name: _____ DOB: _____ Relation: _____

Name: _____ DOB: _____ Relation: _____

Authorization to bring child to office visits

Furthermore, I authorize the following individual(s) to **bring my child in for appointments** and allow them to authorize medical treatment for my child by DCM. I understand that co-payments are due at the time of service, and that I am responsible for payment for services rendered:

Name: _____ DOB: _____ Relation: _____

Name: _____ DOB: _____ Relation: _____

I understand that I may terminate this HIPAA Authorization Form at any time by submitting a request in writing to DCM.

Parent/Legal Guardian's full name: _____ DOB: _____

Parent/Legal Guardian's Signature: _____ Date: _____

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Child's Medical History Form

Name: _____ DOB: _____

Medication Dose How often?

_____

_____

_____

Pharmacy Information

Name:

Phone /Location:

Allergies to Medications? ___ Yes ___No If Yes, to what medication? _____

Past Medical History: *Please check all conditions the child has had*

- □ Abdominal problems
- □ Frequent Temper Tantrums
- □ Pneumonia
- □ Any serious injury
- □ Seasonal Allergies
- □ Joint/Bone Problems
- □ Hay fever/Sinus Problems
- □ Behavior Problems
- □ Skills are behind other kids
- □ School Problems
- □ Heart Problems
- □ Chronic Cough
- □ Asthma
- □ Seizures
- □ Kidney or Bladder infections
- □ Hearing Problems
- □ Broken Bones
- □ Underweight
- □ Constipation
- □ Many ear infections
- □ Vision Problem
- □ Over Weight
- □ Other _____

Social History:

How many brothers or sisters? _____ Grades: _____

Is your child in daycare/after school care? ___Yes ____No

Who lives at home? _____

Is there a smoker in the home/at babysitters? ____Yes ____No

Hospitalizations/Surgery:

Any Hospitalization? ___Yes ___No If yes, when and where? _____

Any Surgery? ___Yes ___No If yes, explain? _____

Family History: Has any blood relative of your child had...

- □ Depression
- □ Lung Disease
- □ Allergies
- □Diabetes
- □ Mental Illness
- □ Asthma
- □ Drug Addiction
- □Alcoholism
- □ Seizures
- □ Bleeding Disorder
- □ Heart Problems
- □ Strokes
- □ Blood Clots
- □ Heart Vessel Surgery
- □ Tuberculosis (TB)
- □ Cancer
- □ High Blood Pressure
- □ Other conditions
- □ Deafness?
- □ High Cholesterol

Parent/Guardian Signature: _____ Date: _____