William T. Lin, M.D., P.A.
2821 E. President George Bush Hwy, Suite 101
Richardson, TX 75082
972-235-9444, FAX: 972-235-9555
www.DrWilliamLin.com

New Patient Information

Childs Information:

Last Name:___________________________ First:__________________________ Middle:__________________________

Date Of Birth (Month/Date/Year)_______________________ Sex (M/F) _______ S.S.#_____________________________

Name of other siblings seen here:____

Referred by: ____________________________________

Mother's Information:

Last Name __________________________ First ___________________________ Middle: __________________________

Address: ____________________________________Apt#:________ City: _____________ State: ______ Zip: _________

Home Phone: ___________________________ Work Phone:_______________________ Cell #__________________

DOB: _________________________ S.S. #________________________________ Email: _________________________

[ ] Check here if you would like to be placed on our monthly email list (Dr. Lin's patients only)

Father's Information:

Last Name: ___________________________ First:_________________________ Middle: _________________________

[ ] Check here if address is same as mother's address.

Address (If different from mother's): ____

Home Phone: ____________________________ Work Phone_________________________ Cell #_________________

DOB: __________________________ S.S.#_________________________________ Email: ______________________

[ ] Check here if you would like to be placed on our monthly email list (Dr. Lin's patients only)

Emergency Contact Person (Other than parents)

Name: ____ Phone: ____

Health Insurance Information:

Name of Insurance: ____

Policy Number: ___________________________________ Group Number: ___________________________________

Name of Primary Insured: _______________________________________ S.S. # _______________________________

Employer: ______________________________________ Phone: ___________________________ DOB: ____________

Consent For Medical Treatment:

I hereby give Dr. William T. Lin permission to provide medical care to ____

Assignment And Release:

I assign all insurance benefits to Dr. William T. Lin and will be responsible for all charges whether or not paid by my Insurance. I hereby authorize Dr. William T. Lin to release all information to secure payment of benefits. I authorize the use of this signature on all insurance submission.

____ _____________________________

Signature of Insured/Guardian Date

Pediatric History Sheet

Birth History: Birthdate: ________________ Birth Hospital: ___________________

Birth weight:_____________, Birth length: _____________, APGAR scores (if known): ____________

Vaginal or Cesarian delivery? ____________ Reason (if Cesarian): ________________________________

Premature or Full-Term?_______________ Estimated due date (if premature): _______________________

Complications w/ delivery: ____

Past Medical History of Child: (Please check)

___ Allergies to foods, medications, etc

___ Surgeries

___ Hospitalizations

___ Ear, Nose or throat problems

___ Heart, lung, or kidney problems

___ Stomach, bone or skin problems

___ Blood problems or cancer

___ Other serious illnesses

Please explain any of the medical conditions checked above: ____________________________________

____

Family History:

Mother's birthdate: _________________, Occupation: _________________________, Smoker? _________

# of pregnancies: _________, # of miscarriages or abortions: ___________

Father's birthdate: _________________, Occupation: _________________________, Smoker? _________

Living at home w/ children (Y/N)? ___________

Siblings names and birthdates: ____

____

Names of other adults (and their relationship to child) living at home: _______________________________

____

Please place a check mark next to any medical condition that exists in the family (including parents, siblings, grandparents, aunts and uncles on both sides of the family):

Diseases of the breathing:
___ Asthma
___ Allergies (hay fever)
___ Persistent cough
___ Cystic fibrosis

Diseases of the stomach/digestion:
___ Persistent constipation
___ Persistent diarrhea
___ irritable bowels
___ stomach ulcers
___ Crohn's disease
___ Ulcerative colitis
___ Eating disorders

Joint Diseases:
___ Juvenile arthritis
___ Lupus

Diseases of the heart or blood vessels:
___ High blood pressure
___ Heart attack (under 50y)
___ Stroke
___ High cholesterol

Diseases of the nerves/brain:
___ seizures/convulsions/epilepsy
___ persistent muscle weakness
___ severe vision impairment
___ mental retardation
___ learning disabilities
___ psychiatric illness

Kidney Diseases:
___ Urinary tract infections
___ Kidney failure
___ Bedwetting

Severe or frequent infections:
___ AIDS
___ recurrent pneumonias
___ Difficulty fighting infections
___ Tuberculosis

Glandular (endocrine) diseases:
___ Thyroid disease
___ diabetes
___ short stature
___ reproductive system diseases

Other diseases:
___ Leukemia
___ Other childhood cancer
___ Infant deaths
___ Bleeding disorders
___ Skin diseases

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, ________________________, the parent/legal guardian for __________________________ understand that as part of my child's health care, William T. Lin, M.D., P.A. originates and maintains paper and/or electronic records describing my child's health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my child's care and treatment,
- A means of communication among the many health professionals who contribute to my child's care,
- A source of information for applying my child's diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices and Privacy Policies* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my child's health information for directory purposes, and
- The right to request restrictions as to how my child's health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that William T. Lin, M.D., P.A. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that William T. Lin, M.D., P.A. reserves the right to change his notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should William T. Lin, M.D., P.A. change his notice, he will send a copy of any revised notice to the address I've provided (via U.S. mail).

I wish to have the following restrictions to the use or disclosure of my health information:
____
____
____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and (circle one) accept / decline the terms of this consent.

___________________________________ ___________________________
Guardian's Signature Date

____
Relationship to Patient

FOR OFFICE USE ONLY
[ ] Consent received by ____________________________________ on ________________________.
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on ______________________________

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OFFICE POLICIES

1. It is the parent's/guardian's responsibility to notify the office of any address, phone, or insurance changes.

2. Please bring your insurance card to each and every visit. If we are unable to verify benefits prior to the office visit, the parent/guardian accompanying the patient will be responsible for payment for charges from services rendered on that day.

3. Insurance companies require collection of your co-pay or contracted percentage of services at each and every visit. If you have a deductible that has not been met, you will be required to pay for the visit in full. If your insurance company does not pay for a service, the charges will be the responsibility of the parent/guardian.

4. We see patients by **appointment only.** Each child needing examination by the doctor should have an individual appointment scheduled. Rescheduling may become necessary if you are more than 15 minutes late for your appointment.

5. As a courtesy, we will attempt to contact you 1-3 business days prior to remind you of your appointment. If for any reason we are unable to contact you, it is still your responsibility to keep the appointment. **There is a $35 fee for failed appointments.**

6. If you need to cancel an appointment, **be sure to call at least 24 hours in advance**. A broken appointment is a loss to everyone. Disregard for this policy is subject to **a $35 service charge** on the account. Multiple "no shows" may result in a fee or dismissal from the practice.

7. There is a **$30.00 fee for returned checks** and a $10 **fee for replacement immunization cards**.

8. There is a **$26.00 fee per child for copies of medical records**. The records will be mailed within 3-5 business days after the request is made and the fee is received. Requests must be made in writing. If the parent requests a facsimile of a child's medical records, the fee is $50.00.

9. Absences from school will only be excused by our office if your child has been seen in the office for the illness.

10. Antibiotics will not be prescribed over the phone. If you feel your child may need an antibiotic, he/she will need to be seen by the physician.

11. Medication refills can be requested over the phone to treat stable, chronic medical conditions that require ongoing medication (i.e., asthma, allergies), as long as the patient is an established patient and has been examined by the doctor within the past 6-12 months. Examination intervals for ADHD will vary between 3-4 months depending on the case.

12. We may require you to bring your child into our office before a referral to a specialist is made. Keep in mind that there are many things that your physician can treat without going to a specialist. If we refer you to a specialist and your insurance requires a referral, we must have **7-10 days advance notice** of the appointment date to secure your referral. It is the parent's/guardian's responsibility to make sure we have all the necessary information. Of course, special circumstances may arise and we will always do our best to accommodate you in these situations.

13. After hours medical advice is taken by Dr. Lin or another covering physician. This service is for urgent medical advice only. For non-urgent medical questions or to make an appointment, please call during normal business hours. There is a $25 service fee for after-hours advice between 10pm and 8am CST and there may be an extra fee for "complex" after-hours advice.

14. If there is an emergency and you are unable to contact Dr. Lin or a physician covering for him, call 911 or take your child to the nearest hospital emergency room.

15. Violation of office policies may result in dismissal from the practice.

By signing below you indicate that you have read and understand the office policies.

__________________________________ ___________________
Signature of parent or guardian Date

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We understand that at times, unexpected events arise, resulting in missed appointments. It is essential that you call our office, as soon as possible in order to allow another patient the opportunity for an equally important appointment.

As a courtesy, we will attempt to contact you by text and/or phone to remind you of your child's appointment. If for any reason we are unable to reach you, it is still your responsibility to keep the appointment.

If an appointment is missed, or not canceled within 24 hours, you will be assessed a $35 fee.

If you are more than 15 minutes late for your scheduled appointment, your appointment may need to be rescheduled for another time. If you are en route to your appointment and running late, please call our office to see if you can still be seen or better served by being rescheduled.

We value your business and ask that you respect our office scheduling policies.

Regretfully, after 3 no call/no shows to our office, we reserve the right to dismiss the patient from our care. Thank you for your cooperation.

Patient Name:___________________________________

Responsible Party Signature:______________________

Date: ________________