ANNA E. LEE, M.D., MEDICAL CORPORATION

Anna E. Lee, M.D. and Siyi Z. Yung, M.D.

PATIENT INFORMATION FORM

PLEASE LIST ALL CHILDREN **Our children are primary patients of ☐ Dr Lee or ☐ Dr Yung**

NAME: LAST	FIRST	M.I.	DATE OF BIRTH	CIRCLE ONE
1.)				M F
2.)				M F
3.)				M F
4.)				M F
STREET ADDRESS			CITY	
STATE ZIP			HOME NUMBER (IF APPLICABLE)	
CHILD(REN) RESIDE WITH:				

PARENT/GUARDIAN INFORMATION ☐ **FATHER** ☐ **MOTHER** ☐ **STEPPARENT** ☐ **OTHER**

NAME: LAST	FIRST	M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER
STREET ADDRESS (If different from child)			CITY	
STATE ZIP		CELL NUMBER		
EMPLOYER		EMAIL ADDRESS		

PARENT/GUARDIAN INFORMATION ☐ **FATHER** ☐ **MOTHER** ☐ **STEPPARENT** ☐ **OTHER**

NAME: LAST	FIRST	M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER
STREET ADDRESS (If different from child)			CITY	
STATE ZIP		CELL NUMBER		
EMPLOYER		EMAIL ADDRESS		

EMERGENCY CONTACT INFO (OTHER THAN PARENTS/GUARDIAN)

NAME	RELATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE

PRIMARY INSURANCE INFORMATION	**SECONDARY INSURANCE INFORMATION**
INSURANCE NAME	INSURANCE NAME
NAME OF SUBSCRIBER	NAME OF SUBSCRIBER
ID#	ID#
GROUP#	GROUP#
RELATIONSHIP TO PATIENT	RELATIONSHIP TO PATIENT

PLEASE SHARE WITH US HOW YOU HEARD ABOUT OUR PRACTICE_____

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NEW PATIENT QUESTIONAIRE

(PLEASE FILL OUT SEPARATE FORM FOR EACH CHILD)

Today's Date:_____
Patient's Name _____Date of Birth_____
Father's Name_____ Date of Birth _____ Occupation _____.
Mother's Name _____Date of Birth _____ Occupation_____
Where does the patient live? (i.e. with both parents, mom, dad, split time, other)_____
_____
If the legal guardian of the patient is someone other than the parents, please provide that information here:
_____

Pregnancy and Birth : (N/A if older than 1 year)

Was the patient full term or premature? _____
If premature, how many weeks was the pregnancy? _____ Birth Weight _____
Was the delivery a vaginal or cesarean section? _____
Were there any problems with the pregnancy or delivery? _____
Were there any problems with the patient after birth?_____
Did your baby receive Vit K injection? _____ Erythromycin eye ointment? _____ Hepatitis B vaccine? _____

Past Medical History: (N/A if Newborn):

Does the patient have any allergies? (food, medications, or others) _____
Has the patient had any hospitalizations? Surgeries? Serious injuries? _____
Does the patient take any medication regularly? _____

Does the patient have any chronic medical problems? Please check any below and/or explain in the space below:

Chronic headaches	____	Asthma	____	Seizures	____	Eczema/skin disease	_____
Chronic ear infections	____	Seasonal Allergies	____	ADHD	____	Bladder infections	_____
Constipation/diarrhea	____	Heart Disease	____	Diabetes	____	Congenital defect	_____

Other/explain _____

Has the patient's development been normal, or has he/she had delays? _____
_____

Are the patient's immunizations up to date? Yes____ No ____ Other _____

Family History:

Do any of your family members (patient's parents, grandparents, siblings, aunts, or uncles, first cousins) have any of the following medical condition(s)? Please circle any below and/or explain in space below:

Anemia, Asthma, Allergies, High Blood Pressure, Diabetes, Heart Disease, Cancer, Mental Illness, Drug or Alcohol Addictions, Neurological Disorders, Infectious Disease, Kidney reflux/disease or blood disorder
Others/Explain: _____

Please provide sibling's names, dates of birth and general health: _____
_____

_____

Are all your children living? _____

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CONSENT FORM

PATIENT NAME(S): _____ DATE OF BIRTH: _____

_____ _____

_____ _____

_____ _____

PLEASE ACKNOWLEDGE THE FOLLOWING REQUESTS FOR AUTHORIZATION:

_____ (initial) I hereby authorize Anna E. Lee, M.D., Inc. to provide medical treatment to the patient on this form.

_____ (initial) I hereby authorize third parties to pay directly to Anna E. Lee, M.D., Inc. any insurance benefits due for services rendered on behalf of the named patient.

_____ (initial) I authorize Anna E. Lee, M.D., Inc. to furnish my insurance company and/or third-party payers (or their representatives), any medical information necessary to process our insurance claim.

_____ (initial) I hereby acknowledge that I have reviewed a copy of the Financial Policy and I understand that I am responsible for payment of all charges for medical services rendered to the named patient.

_____ (initial) As required by the Privacy Regulations, I hereby acknowledge that I have reviewed a current copy of "Notice of Privacy Policy". I have read the Privacy Policy and understand my rights contained in the notice.

_____ (initial) By way of my signature, I provide Anna E. Lee, M.D., Inc. my authorization and consent to use and disclose my child's protected healthcare information for the purpose of treatment, payment, and healthcare operations described in the Privacy Policy.

As required by the Health Insurance Portability and Accountability Act of 1996 **(HIPAA)**, you have a right to request that communication concerning your personal health information be made through confidential channels. Anna E. Lee, M.D., Inc. will try to accommodate all reasonable requests.

I hereby request the use of the following confidential channels for the communication of information related to my child's personal health, treatment, or payment for treatment.

Please indicate preferences:

Primary Cell Phone Number: (_____)_____ relation to patient_____

Secondary Cell phone Number: (_____)_____ relation to patient_____

_____ (initial) I authorize this office to leave messages regarding my child's health

_____ (initial) I authorize this office to leave messages regarding appointments

_____ (initial) I authorize this office to leave messages regarding my child's test results

_____ (initial) I authorize this office to leave messages regarding billing

_____ (initial) I authorize this office to text (or email) reminders, recalls, general information or portal information.
Email(s):_____

Signature: _____ Date:_____

Printed Name: _____ Relation to Patient:_____

ANNA E. LEE, M.D., MEDICAL CORPORATION

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OFFICE FINANCIAL POLICY

Thank you for choosing our office for your child's medical care. We are truly honored and appreciate your trust in our office to provide excellent medical care to your child(ren). One important aspect in maintaining this important physician-patient relationship is a mutual understanding of our office billing and payment policies. Please review our policy as listed below and we will be happy to answer any questions you may have.

As a courtesy to our patients and parents, our office will submit claims to your insurance company on your behalf, for office visits and services provided by Dr. Lee, Dr Yung or their designee. However, please understand that this is a **courtesy** on our part, and the **insurance policy is between you and your insurance company**. Due to the complex nature of insurance policies and vastly different insurance plans available we hope that you familiarize yourself with your individual insurance policy, especially paying attention to the details of what is covered and what is not covered by your plan, your co-payments, and deductibles. Though we will try our best to assist you, please, understand that this ultimately remains your responsibility.

Please review our financial policy below:

- Please present your current insurance card at each of your child's visits.
- Please notify us at the time of visit if there are any changes in insurance coverage and/or address change.
- Your insurance co-payment is due at the time of the office visit. **A $10.00 billing fee will incur if co-payment is not paid at the time of the visit** and a bill will be generated.
- Please remember to add your **newborn baby to the parent's policy within the first 30 days** after birth to ensure that your newborn will not have any gaps in medical insurance coverage.
- Patient balances are billed after we receive your insurance plan's explanation of benefits (EOB). Please remit your balance **within 2 weeks** of your receipt of your bill.
- If you have an HMO policy, please make sure that **Dr. Anna E. Lee** or **Dr Siyi Yung** is selected as your child's primary care physician through Greater Tri-City IPA (GTCIPA). Please, confirm this information on your card once you receive your insurance card. If we are not your designated PCP, you will be responsible for the full cost of the visit, payable at the time of the visit. A receipt of your payment will be provided for you to submit your claim to your insurance company.
- A $25.00 fee will be applied to all returned checks.
- We provide services by appointment only. **If you are unable to make your appointment, we ask that you notify our office at least 4 hours prior to the time of your appointment**. You will be assessed a **charge of $40.00 if we are not notified 4 hours prior to your appointment time.**
- For your convenience, we accept cash, check, Mastercard, VISA, and American Express. Payments by credit card may also be made over the phone directly with our billing office staff.
- Please direct your inquiries regarding bills from outside facilities, such as the hospital laboratory, or radiology, to the respective facilities' business offices.

We appreciate you taking the time to review our policy. By being aware of the information regarding your financial responsibilities beforehand, we hope that we can focus on the "care" of your children when you are in our office. However, we understand that special circumstances may arise on occasion that may challenge the wisdom of said policy. Please contact our billing office if you have any questions or anticipate need for special arrangements.

I have read and understand the above financial policy and agree to the above arrangements.

Please list all your children:

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

_____ _____

Responsible Party Name Relationship

_____ _____

Responsible Party's Signature Date

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AUTHORIZATION TO TREAT MINOR

Use of this affidavit is authorized by part 1.5 (commencing with section 6550) of division 11 of the California family code

This form is an affidavit to authorize medical care including immunizations, physical exams, testing and/or treatment for the purpose of medical diagnoses and medical care, which is deemed advisable and if rendered by Dr. Lee or Dr Yung or their designee.

I (we), the undersigned parent(s)/guardian(s) of: _____

_____

give authorization to the following qualified relatives and/or caregivers to seek care for the minor(s) indicated above.

This authorization will remain in effect until further *written* notice.

If you DO NOT wish to designate anyone else other than the parent(s)/guardian(s) to be present and to give consent for treatment (except in case an emergency), please indicate **N/A** below**.** **NOT FOR PARENTS/LEGAL GUARDIANS**

	CAREGIVER NAME	**RELATIONSHIP TO PATIENT**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Please note: Caregivers listed above will be required to show picture ID at each office visit.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____ _____

Parent/Guardian's Name (Print) Parent/Guardian's Signature

_____ _____

Witness Date