PATIENT INFORMATION FORM

Date of Birth: ___________

Name: ____ SSN: _______________
(LAST) (FIRST) (M.I.)
Home Address: ____________________________________ Phone #: _______________
City: ________________ State ____ Zip ___________ Driver's License # _______________

Alternate Phone # (cell) ______________ Email ______________________________
Gender MALE ( ) FEMALE ( ) Marital Status: ( ) Married ( ) Single ( ) Div ( ) Sep ( ) Widow (er)

Employer Name: ___________________________ Occupation ___________________
Address: _________________________________ Phone #: _____________________
May we call you at work? ( ) Yes ( ) No

RESPONSIBLE PARTY FOR PAYMENT (IF OTHER THEN PATIENT):
Name: __________________________ DOB ______________ SSN _______________
Address: ____________________________________ Phone # _______________
Employer: ___________________________________ Phone # _______________
Address: ____

REFERRING PHYSICIAN ____

INSURANCE INFORMATION

PRIMARY INSURANCE _______________________ SUBSCRIBER ________________
SECONDARY INSURANCE _____________________ SUBSCRIBER ________________

MEDICARE? ( ) YES ( ) NO IF YES, IS MEDICARE ( ) PRIMARY OR ( ) SECONDARY
IF MEDICARE IS PRIMARY, DO YOU HAVE A SECONDARY INSURANCE PLAN? ( ) YES ( ) NO
IF YES, IS THIS PLAN A MEDI-GAP OR EMPLOYER SUPPLEMENT (CIRCLE ONE)

IF YOU ARE COVERED BY MEDICARE AND YOU OR YOUR SPOUSE ARE STILL WORKING PLEASE COMPLETE:

ARE YOU EMPLOYED FULL TIME? ______ OR PART TIME? ________
IS YOUR SPOUSE EMPLYOED FULL TIME? _______ OR PART TIME? ________
ARE YOU OR YOUR SPOUSE ELIGIBLE FOR GROUP HEALTH INSURANCE THROUGH EMPLOYER? ( ) YES ( ) NO
IF YES, INSURANCE COMPANY NAME: _______________________________
SUBSCRIBER: _______________________________

I, THE UNDERSIGNED, HAVE INSURANCE COVERAGE WITH ___________________________
(INSURANCE COMPANY)
AND ASSIGN DIRECTLY TO DAVID H.Y. LIN, M.D. ALL SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. IN UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE DAVID H.Y. LIN, M.D. TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

DATE: _______________ SIGNED: ____

DISCLAIMER

Dr. Lin has financial interest in the Laser Surgery Center. If such an interest is of concern to you, please feel free to discuss this with Dr. Lin or the staff.

REVIEW OF SYSTEMS

Eye Disease	____	Cough: frequent	____	Chest Pain	____
Eye Injury	____	chronic	____	or pressure	____
Impaired Sight	____	productive?	____	Angina pectoris	____
Ear Disease	____	color	____	Palpitations	____
Impaired Hearing	____	blood	____	Swelling of feet	____
Any trouble w/ nose	____	Vomiting of blood	____	ankle	____
w/ mouth	____	Rectal bleeding	____	abdomen	____
w/ throat	____	Hemorrhoids	____	Blood in urine	____
Fainting Spells	____	Black tarry stools	____	albumin	____
Convulsions	____	Bloody stools	____	sugar	____
Paralysis	____	Constipation	____	Difficulty starting urination	____
Dizziness	____	Diarrhea	____	or narrowed stream	____
Headaches: frequent	____	Change in appetite	____	Burning on urination	____
Severe	____	Change in eating habits	____	Abnormal thirst	____
Enlarged glands	____	Change in bowel habits	____	Recent weight loss	____
Thyroid:		Shortness of breath	____	Abdominal pain	____
Overactive	____	on exertion	____	gas	____
Underactive	____	at night	____	belching	____
Enlarged	____	Wheezing	____	indigestion	____
Enlarged goiter	____			Difficulty swallowing	____

Date of last 1. Influenza vaccine________ 2. Pneumonia vaccine________ 3. Bone density________

FAMILY HISTORY

Mother: age ___ If deceased, age at death ___ Cause of death ____________________________

Father: age ___ If deceased, age at death ___ Cause of death ____________________________

Brothers, sisters: List ages. If deceased, age at death and cause of death ____________________
____

Children: List ages. If deceased, age at death and cause of death __________________________

IS THERE ANY FAMILY HISTORY OF THE FOLLOWING? IF SO, PLEASE STATE WHICH FAMILY MEMBER.

Cancer__________ Tuberculosis__________ Blood disease____________

Diabetes__________ High Blood Pressure__________ Hepatitis________________

Heart trouble ________ Asthma, hives, hay fever _________ Colonic Polyps ___________

Crohn's disease_______ Ulcerative Colitis____________ Peptic Ulcers_____________

Patient's Name ______________________

PERSONAL HISTORY

Check if you have the following:

Rheumatic Heart Disease	____	High Blood Pressure	____	Kidney/Bladder Stone	____
Heart Attack	____	Arthritis/Rheumatism	____	Prostate Trouble	____
Pneumonia	____	Bone or Joint Disease	____	Gonorrhea/Syphillis	____
Tuberculosis	____	Bursitis/Sciatica	____	Stomach Ulcer	____
Pleurisy	____	Epilepsy	____	Liver or Gallbladder disease	____
Bronchitis	____	Migraine Headaches	____	Colitis or bowel disease	____
Asthma	____	Stroke	____	Jaundice/Hepatitis	____
Emphysema	____	Neuritis	____	Blood in stools	____
Hay Fever/Eczema	____	Skin Disease	____	Colonic Polyps	____
Cancer	____	Pancreatic Disease	____	Diabetes	____
Kidney Disease	____				

Allergies: (Including allergies to medications and chemicals)

Previous Surgery: (Specify type and date)

Previous injuries or trauma: (Specify type of injury and date)

Recent tests: (Please include x-rays, skin tests, EKG's, Laboratory tests, etc.)

Medication presently being taken (include milligram strength and directions)

Habits: (Smoking, Alcohol intake, etc.)
If you are a smoker, please indicate how many packs per week and duration of smoking habit:

Background history: (Place of birth, education, occupation, etc.)

Ethnicity:

White	____	Black or African American	____	Black Hispanic or Latino	____
American Indian	____	Alaskan Native	____	White Hispanic or Latino	____
Native Hawaiian	____	Other Asian	____	Filipino	____
Other Pacific Island	____	Japanese	____	Chinese	____
Korean	____	Samoan	____	Tongan	____
Guamanian	____	Vietnamese	____	Unknown	____

Preferred Language: ____________________

Name: ______________________________

DAVID H.Y. LIN, M.D.
905 SAN RAMON VALLEY BLVD., SUITE 206
DANVILLE, CA 94526
(925) 831-9200

Privacy Officer: David H.Y. Lin, M.D. **Effective Date:** February 1, 2003

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.

David H.Y. Lin, Ph.D., M.D.

Gastroenterology – Internal Medicine
Diplomate American Board of Internal Medicine and Gastroenterology

905 San Ramon Valley Blvd., Suite 206
Danville, CA 94526

Tel. (925) 831-920C
Fax. (925) 831-931'

FINANCIAL POLICY

INSURANCE – CASH PATIENTS
Patients are financially responsible for services provided and are expected to pay at the time of service. As a courtesy, we will bill your insurance; however, you will need to provide complete billing information at the time of your visit. A copy of your charges, if requested, will be supplied to you so that you may follow up with your insurance company personally.

HMO-PPO PATIENTS
If you are a member of an HMO/PPO, you are required by your health plan to pay a co-payment at the time of your visit. We cannot waive the co-payment amount as a contracted provider. the **Co-payments will be collected at time of service.** Non-covered services must be paid at the time of the service.

MEDICARE
We are participating providers in Medicare, which means that we accept Medicare assignment and accept Medicare's allowable amount as payment in full, once your deductible and co-payments have been made. We will bill MediCare for you, as well as your supplemental insurance. You must provide us with valid cards from MediCare and other insurance. Without these documents we cannot bill your insurance and payment will be expected from you at the time of your visit. Deductibles will be paid at the time of service.

CANCELLATIONS – NO SHOWS

If you are scheduled to see Dr. Lin and are unable to keep your appointment, please contact our office as soon as possible so we may schedule your time for another patient. If you cancel appointments with less than 24 hours' notice (48 hours' notice for procedures), you may be subject to a charge consistent with the time allowed for the visit. Failure to show up for your appointment creates gaps in our schedule and affects our ability to provide appropriate care to all our patients. **"No Shows" and/or cancellations of office visits with less than 24 hours' notice will result in a minimum charge of $25.00. "No Shows" and/or cancellations of procedures with less than 48 hours' notice will result in a minimum charge of $100.00. This charge is NOT covered by your insurance company. Repeated "No Shows" or cancelled appointments, without at least 24 hours' notice, may be cause for dismissal from our practice.**

COMPLETION OF FORMS/PHOTOCOPYING OF MEDICAL RECORDS
A minimum charge of $25.00 will be charged with a maximum of $100.00.

If you are experiencing financial hardship, please ask to speak with our office manager regarding a payment plan.

A $25.00 charge will be applied for returned checks.

Signed:______________________________
Date:______________________________
I acknowledge I have read the above financial policy

David H. Y. Lin M.D.
Gastroenterology
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Danville, CA 94526

HIPAA Privacy Authorization Form

Authorization for use Or Disclosure of Protected Health Information

Acknowledgement Of Receipt Of Notice Of Privacy Practice

1. **Authorization**

I authorize Dr. David H.Y. Lin, M.D. to use and disclose the protected health information as needed.

2. **Effective Period**

This authorization for release of information covers the period of

☐ ONE YEAR

OR

b. _____ All past, Present, and Future periods.

3. **Extend of Authorization**

1. This medical information may be 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.

2. 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 contest a claim.

X____ DATE______________

SIGNATURE OF PATIENT OR PERSON REPRESENTING PATIENT

X____ DATE______________

PRINT NAME OF PATIENT OR PERSON REPRESENTING PATIENT

David H. Y. Lin M.D.
Gastroenterology
905 San Ramon Valley Blvd., Suite 206
Danville, CA 94526

HIPAA CONSENT
CONSENT TO LEAVE MESSAGES

Patient Name:______________________________ Date:____________________
(print)

I wish to be called at home☐ ; cell☐; other☐ (check all that apply) regarding my care and follow-up. The best telephone number(s) to reach me are:

______________________________home ______________________________cell

______________________________other

I do☐, I do not☐ give permission to leave relevant medical information on my answering machine or voice mail.

I do☐, I do not☐ want relevant medical information shared with the person who may answer the telephone. The name(s) of the individual(s) with whom you may leave pertinent information are:

____

____

______________________________ ____________________
Patient Signature Date