Rev: 10/30/20

PATIENT REGISTRATION

Today's Date:_____/_____/_____

Patient Name:_____ DOB:_____ Gender:_____

Address:_____

Parent/Guardian Name:_____ Relationship:_____

Address (if different):_____

Day #:_____ Evening #:_____

Legal Custody? Y N Physical Custody? Y N

Parent/Guardian Name:_____ Relationship:_____

Address (if different):_____

Day #:_____ Evening #:_____

Legal Custody? Y N Physical Custody? Y N

Insurance:_____

Policy #:_____ Group #:_____

Copay:_____

Insured Party:_____ Insured Party's DOB: _____

Address (if not listed above):_____

Pediatrician Name:_____ Last Visit:_____

Preferred Pharmacy:_____

Address:_____

Rev: 10/30/20

CHILD QUESTIONNAIRE

Patient Name:_____ DOB:_____

Name of Person Completing Form:_____ Relationship:_____

Developmental History

Problems during Pregnancy or Delivery:_____

Substance or Medication Use During Pregnancy:_____

Concerns with Motor Skills:_____

Concerns with Language Skills:_____

Other Developmental Concerns:_____

Medical History

Current Medical Issues:_____

_____

Past Medical Issues:_____

_____

Review of Medical History

Difficulty With:	Yes	No	Comments
Chronic Fatigue			
Recent Weight Loss/Gain			
Fever, Chills, Sweats			
Vision			
Hearing			
Nose, Throat			
Heart			
Asthma			
Stomach, Digestion			
Urinary			
Muscle			

Difficulty With:	Yes	No	Comments
Skin			
Headaches			
Seizures			
Heat or Cold Intolerance			
Bruising or Anemia			
Environmental Allergies			
Surgeries, Major Hospitalizations			
Serious Injuries			
Motor tics (blinking, squinting, head tossing)			
Vocal tics (sniffing, grunting, throat clearing)			
Exposure to toxic chemicals			
Allergies to Medications			

Current Medications, Supplements, Non-Medical Treatments

Name	Dose and Frequency	Indication

Psychiatric History

Current Therapist:_____

Previous Therapist:_____

Previous Psychiatrist:_____

Previous Medications:_____

_____

Psychiatric Hospitalizations:_____

_____

Social/Family History

Others at Home:_____

_____

Family History of Psychiatric Illness:_____

_____

_____

Family History of Medical Illness:_____

_____

_____

Relevant Custodial/Legal History:_____

_____

_____

School:_____ Grade Level:_____

School Contact:_____ Phone #:_____

School Services:_____ IEP? Y N 504? Y N

History of School Problems:_____

_____

Anything Else:_____

_____

_____

_____

_____

_____

_____

_____

FEE AGREEMENT AND CANCELLATION POLICY

I. FINANCIAL RESPONSIBILITY:

If you are not using your insurance, I charge $400.00 for an initial evaluation and consultation. I charge $300.00 for 50 minute therapy appointments and $150.00 for 25 minute medication/therapy visits. Payment is due at each visit. I accept personal checks, cash, and credit cards (VISA/MC).

By signing this you, the responsible party, are acknowledging full financial responsibility for services rendered by Clara Kim, MD. Payment of these charges is collected at each session. You, the responsible party, understand that any charges incurred by Clara Kim, MD with collection of payments (such as insufficient funds, collection costs, or denial of insurance benefits) will be forwarded on to you, the responsible party.

Please inform me in the event your insurance changes. For insurances that I do not accept, you, the responsible party, will be responsible for payment of the full fee as stated above.

II. LATE CANCELLATION/ NO SHOW POLICY

I will bill you $50 for a missed 25-minute appointment and $100 for a missed 50-minute appointment. A late cancellation is when you cancel on the same day of the appointment or after 5 pm the previous day. If a late cancellation can be rescheduled within the week there is no cancellation fee. I waive fees for the first late cancellation or no show per calendar year. Insurance does not reimburse for missed appointments. I will require this fee to be paid prior to scheduling a new appointment.

III. SERVICE TERMINATION

You, the responsible party, understand that if you do not make payments for services that Clara Kim, MD reserves the right to suspend treatment, upon appropriate notice, and will assist in making a referral elsewhere. If treatment is to be terminated I will treat you, the responsible party, for a brief period of time until another provider is identified, and I will send copies of your record to your new provider upon receipt of your authorization to do so. Even if treatment is to be terminated or transferred elsewhere, in the event of an emergency I will provide appropriate and necessary care.

I, the responsible party, have read and fully understand and agree to the above fee agreement and cancellation policy.

Client's name: _____ DOB:_____

Responsible party's name:_____ Relationship:_____

Responsible party's signature:_____ Date:_____

Witness Signature:_____ Date:_____

NOTICE RECEIPT

By signing this form, I acknowledge that I have received, read and understand the brochure "Notice of Policies and Practices to Protect the Privacy of Your Health Information" provided by Clara Kim, MD. The Notice describes how mental health and medical information about me or my child may be used and disclosed and how I can get access to this information.

Client's name: _____ DOB:_____

Responsible party's name:_____ Relationship:_____

Responsible party's signature:_____ Date:_____

Witness Signature:_____ Date:_____

Rev: 10/30/20

RELEASE OF INFORMATION AUTHORIZATION: PRIMARY CARE

Patient Name:_____ DOB:_____

I request and authorize Clara Kim, MD to release and receive health information from the patient's pediatrician:

Pediatrician Name:_____ Phone #:_____

Address:_____ Fax #:_____

City, State, Zip:_____

Clara Kim, MD
300 W Main St, Bldg B
Northborough MA 01532
Phone: (508) 723-6141
Fax: (774) 209-4330

This request and authorization applies to only the following protected health information:
(Please initial to specifically authorize the use and/or disclosure of:)

____ Initial Psychiatric Evaluation
____ Outpatient Progress Notes
____ Medication History
____ Psychological Test Report
____ X-Ray Reports (_____)
____ Other (_____)
____ Clinical Summary
____ Discharge Summary
____ Verbal Communication
____ Consultation Report (_____)
____ Laboratory Reports (_____)
____ **Initial Here for All of the Above**

Purpose(s) of this use/disclosure:
____ To coordinate care

During the following approximate time period or dates:_____
Authorization expires:_____ If no date specified, the Authorization will expire 1 year after signed.

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Clara Kim, MD. I understand that Dr. Clara Kim may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug/alcohol treatment or use.

Responsible party's name:_____ Relationship:_____
Responsible party's signature:_____ Date:_____
Witness Signature:_____ Date:_____

I request a copy of this signed authorization: ____

RELEASE OF INFORMATION AUTHORIZATION: SCHOOL

Patient Name:_____ DOB:_____

I request and authorize Clara Kim, MD (Psychiatrist) to my child's school as written below:

____ Release the health care information described below to:

____ Receive the health care information described below from:

Name:_____ Phone #:_____

Address:_____

City, State, Zip:_____

Please fax to 774 - 209 - 4330 or mail to Clara Kim, MD, 300 W Main St, Bldg B, Northborough MA 01532

This request and authorization applies to only the following protected health information:

____ E-mail Updates: I understand that E-mail is not HIPAA secure and could be viewed by third parties.

____ Verbal Communication

Purpose(s) of this use/disclosure:

____ To coordinate care

____ Other (_____)

During the following approximate time period or dates: Period of School Attendance

Authorization expires:_____ If no date specified, the Authorization will expire 1 year after signed.

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Clara Kim, MD. I understand that Dr. Clara Kim may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug/alcohol treatment or use.

Responsible party's name:_____ Relationship:_____
Responsible party's signature:_____ Date:_____
Witness Signature:_____ Date:_____

I request a copy of this signed authorization: ____

INSURANCE AUTHORIZATION OF BENEFITS

AND RELEASE OF AUTHORIZATION

1. ASSIGNMENT OF BENEFITS

In consideration for services and treatment rendered, I hereby assign, transfer and set over unto Clara Kim, MD all health insurance now due to become due and payable to me. I hereby direct my insurance company to pay such benefits directly to Clara Kim, MD in consideration of services furnished and to be furnished by Clara Kim, MD. I understand that I am financially responsible to Clara Kim, MD for charges not covered or paid by this authorization.

2. RELEASE OF INFORMATION

Authorization is hereby granted to release Protected Health Information (PHI) as may be necessary for the completion of my psychological service claims. I understand that PHI will be disclosed to my health insurer for billing and utilization review purposes. This information may include information from my psychological record that concerns mental illness, drug/alcohol information, sexually transmitted disease, HIV, AIDS, termination of pregnancy and/or domestic violence.

Clara Kim, MD shall provide copies of my psychological records to any physician or facility with your signed consent (i) for the purpose of facilitating the transfer or referral of my care and (ii) to my referring/primary care doctor as appropriate for coordination of care. I hereby release Clara Kim, MD from all legal liability that may arise from the release of information requested.

3. HEALTH MAINTENANCE ORGANIZATION

ATTENTION: Health Maintenance Organization (HMO) Subscribers and Preferred Provider Organization (PPO) Subscribers MUST follow HMO/PPO referral requirements for services rendered or it may result in nonpayment by your HMO/ PPO.

I have read, fully understand, and agree to the above authorization of benefits and release of information.

Client's name: _____ DOB:_____

Responsible party's name:_____ Relationship:_____

Responsible party's signature:_____ Date:_____

Witness Signature:_____ Date:_____