**PATIENT REGISTRATION FORM**

**LEE INTERNAL MEDICINE ASSOCIATES PLLC**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate:­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: (circle) Male Female Marital Status: (circle) Single Married Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Daytime Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Name/City/Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR A MINOR- THE FINANCIALLY RESPONSIBLE PERSON**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate:­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: (if different from patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Daytime Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

Please provide your identification and insurance card(s) to be copied. If your insurance information is not provided within 24 hours, you will be billed for the services rendered.

Please mark all that apply: This visit is related to an AUTO ACCIDENT\_\_\_\_\_\_\_If yes, date of injury\_\_\_\_\_\_\_\_

This visit is related to an INJURY AT WORK\_\_\_\_\_\_\_ If yes, date of injury\_\_\_\_\_\_\_

Claim # ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This patient does not have insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1st Insurance Co. Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_Policy Holder Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2ns Insurance Co. Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_Policy Holder Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3rd Insurance Co. Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_Policy Holder Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the release of medical and other information to my insurance company for review of my coverage and/or the processing of claims for services rendered to the patient listed above. I permit a copy of this authorization to be used in place of the original. I understand that i am responsible for any charges incurred that are not covered by the insurance company. I have read this information and understand it. I understand that I am responsible for my insurance co-pay at the time of visit.

Responsible Party Signature:­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BEN LEE, D.O, MARIA MARKOSYAN-KARAPETYAN, M.D.**

**NEW PATIENT HEALTH HISTORY/REVIEW OF SYSTEMS**

**(TO BE COMPLETED BY PATIENT)**

**PAST MEDICAL HISTORY**

List any serious illnesses you have had or have now Onset

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

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**PAST MEDICAL HISTORY**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

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**ALLERGIES**

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**MEDICATION**

List any medication you are now using (including vitamins, herbal supplements, laxatives, aspirin, birth control pills)

Name: Dose: How often?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Ben Lee, D.O., Maria Markosyan-Karapetyan, M.D.**

10415 Grand River Ave. Ste. 100 Brighton, MI 48116

Phone: 810-227-1020 Fax: 810-227-4930

**AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBER OR FRIEND WITHOUT POWER OF ATTORNEY**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient), herby give the following person(s) authorization

to obtain information regarding my:

\_\_\_\_\_\_Confirm appointments/leave messages

\_\_\_\_\_\_ Lab work/test results

\_\_\_\_\_\_Billing information

\_\_\_\_\_\_ALL OF THE ABOVE

\_\_\_\_\_\_NONE OF THE ABOVE

Person1:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person 2:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person 3:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person 4:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have been offered and received a copy of Lee Internal Medicine Associate’s privacy policy

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDITIONAL PERSONAL HISTORY**

|  |  |  |
| --- | --- | --- |
| **Immunization History:**  (check box if you have had and indicate when)  Tetanus (Dtap)\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Gardasil \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Pneumococcal\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Hep B\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Zostavax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Influenza\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Have you had any of the following? (and when)**  Hemoccult \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Colonoscopy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mammogram\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Have you had any of the following? (and when)**  EKG\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Stress Test\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  PSA (men only)\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Echo\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**SOCIAL HISTORY**

Do you smoke? Yes No If yes, how many packs per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years of use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Former smoker?\_\_\_\_\_\_\_

Alcohol use? Yes No If yes, how frequently?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Illicit drug use? Yes No If yes, identify drug(s) and frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **IF LIVING** | | | **IF DECEASED** | |
| **Relationship** | **Age** | **Health Problems** | **Age at Death** | | **Cause of Death** |
|  |  |  |  | |  |
| Mother |  |  |  | |  |
| Father |  |  |  | |  |
| Other |  |  |  | |  |
|  |  |  |  | |  |
|  |  |  |  | |  |
|  |  |  |  | |  |



Ben Lee D.O., Maria Markosyan-Karapetyan, M.D.

Lee Internal Medicine Associates

10415 Grand River Ave Ste. 100

Brighton, MI 48116

Phone: 810-227-1020 Fax: 810-227-4930

For all patients:

Due to the new healthcare reform laws and meaningful use requirements, we are required to ask for the following information:

* Ethnicity
* Race
* Primary Language

Please provide the information below:

**Ethnicity:**

Hispanic/Latino ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Not Hispanic/Latino \_\_\_\_\_\_\_\_\_\_

**Race:**

American Indian or Alaska Native\_\_\_\_\_\_\_\_\_\_

Asian or Asian American \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

African or African American \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Native Hawaiian or Other Pacific Islander\_\_\_\_\_\_\_\_\_\_

Caucasian or European American \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Language:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The only people who see this information are registration staff, administrators for the practice and the people involved in quality improvement and oversight. The confidentiality of what you have entered on this form is protected by law. This information is entered into the computer as discreet data. Your name is not on this form and it will be destroyed after recorded.

You have the right to refuse to provide this information. This makes no difference to us as your providers. Please indicate your refusal below.

**Declined** \_\_\_\_\_\_\_\_\_\_ **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Thank you for your cooperation.

**BEN LEE, D.O., MARIA MARKOSYAN-KARAPETYAN, M.D.**

**PATIENT-CENTERED MEDICAL HOME**

**PATIENT AGREEMENT**

A Patient-Centered Medical Home promotes a close partnership between you and your personal physician. Patients who chose to receive care in this way have the benefit of a medical home, overseen by a primary care physician of their choice, to help them through today's' complex system.

**Your Personal Physician:**

* Is trained to provide first contact, constant and complete care for you.
* Will provide all of your primary health care needs and arrange any professional health care visits and referrals to community service agencies when appropriate.
* Will work closely with you, your family and other physicians to develop health care goals and discuss treatment options to achieve the best possible patient-centered outcomes.

**You will be expected to:**

* Actively participate in decision making and feedback to ensure your expectations are being met.
* Provide updated health information to your personal care physician.
* Actively participate and comply with your care plan.

The Patient-Centered Medical Home includes acre for all stages of your life and to ultimately make your life healthier. Talk with your doctor about any questions.

Patient Name: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today's Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BEN LEE, D.O., Maria Markosyan-Karapetyan, M.D.**

**NOTICE OF USE AND DISCLOSE OF PROTECTED HEALTH INFORMATION**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUMAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are committed to protecting the privacy of our patient’s personal information. All our employees are required to sign confidentiality agreements and are required to comply with our confidentiality policies.

We may use or disclose your protected health information for the purposes of treatment, payment or practice operations only with your written consent. For example, we may contact another physician to coordinate your care, submit a claim to an insurer, or look at your file to perform internal quality monitoring. We must obtain your written authorization for any other use or disclosure. You may revoke your consent authorization at any time in writing. This will not apply to information used or disclosed while the consent or authorization was in effect.

We will provide access to your information, without your consent or authorization, when required to do so by law or regulation. Access may be granted to public health and law enforcement authorities, healthcare oversight agencies, government benefit programs, employers (in cases of work-related illness or injury), courts and administrative tribunals.

We may contact you to provide an appointment reminder or information about treatment alternatives or other health-related benefits and services.

You have the right to access and amend your information, request an accounting of any disclosures, request restrictions on use and disclosure of your information, request a copy of this notice, or receive confidential communications. If you request restrictions on the use and disclosure of your information, we are not required to grant your request. You may exercise your rights by contacting the individual identified at the conclusion of this notice.

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the most current notice in effect.

We reserve the right to change the terms of our notice and to make new notice provisions effective for all protected health information that we maintain. We will provide you with revised notice by mail.

If you believe that your privacy rights have been violated, you may complain to us or the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

This notice is effective April 8, 2013

The undersigned acknowledges that he/she has received a copy of this notice of privacy practices.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address/city/state/zip

**Lee Internal Medicine Associates**

**Appointment Policies**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting treatment.

Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit due to a seemingly "full" schedule. **If an appointment is not canceled within at least 12 hours prior to the appointment or you do not show up for your appointment, you will be charged $25.** We also understand that delays can happen, however, we must try to keep other patients and the doctor on time. If a patient arrives 15 or more minutes beyond their scheduled appointment time, we **MAY** have to reschedule the appointment.

**Thank you for your understanding.**

I have read and understand the above appointment policy.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LEE INTERNAL MEDICINE ASSOCIATES

GENERAL CONSENT TO TREATMENT

I request and authorize physician office as my physician, his assistants or designees (collectively called "the physicians" may deem necessary or advisable. This care may include, but is not limited to, routine diagnostic radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my physician(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient's) care is directed by my (the patient's) physicians, and that other personnel render care and services to me (the patient) according to the physicians' instructions.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to the results of such diagnostic procedure or treatment.

I authorize the facility to contact health care providers from whom I have received treatment to obtain medical information and/or records including but not limited to *commercial pharmacies i.e., Walgreens, CVS, alcohol, and other drug treatment records* for verification of my medications.

I have been informed and understand that HIV (human immunodeficiency virus)/AIDS and HBV (hepatitis B virus) test may be performed on me without my consent if a health care professional, facility employee or First Responder sustains an exposure to my blood or other body fluid.

**ASSIGNMENT OF INSURANCE BENEFITS**

Medicare Certification: I certify that the information provided by me in applying for payment under the Title XVII of the Social Security Act is correct and request payment on my behalf of all authorized benefits.

I herby authorize and instruct my insurance to make payment directly to the facility benefits otherwise payable to me. I agree to personally pay for any facility or physician charges that are not covered by or collected from any applicable insurance program, including any deductibles and coinsurance amounts.

I HAVE HAD THE OPPORTUNITY TO READ THIS FORM (OR HAVE IT READ TO ME) ASK QUESTIONS AND HAVE THESE QUESTIONS ANSWERED.

**AWKNOWLEDGEMENT OF PRIVACY PRACTICES**

Lee Internal Medicine Health Notice of Privacy Practices provides information about how protected health information about me (the patient) - including information about human immunodeficiency virus (HIV), AIDS-related complex (ARC); and acquired immunodeficiency syndrome (AIDS); and including substance abuse treatment records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any; and psychological and social services records, including communications made by me to a social worker or psychologist (if any)- may be used and disclosed. I have been offered an opportunity to review the Notice before signing this consent. I understand that the terms of the Notice may change and that I may obtain a revised copy by contacting the physician's office at (810) 227-1020 and requesting this   
Notice be mailed to my (the patient's) attention.

My signature below indicates I understand and agree to all of the items outlined above.

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_