Christophe S. Lee, M.D.
Diplomat American Board of Orthopaedic Surgery
complex reconstructive hand surgery | QME

LEEORTHOPAEDICINSTITUTE

Daniel D. Lee, M.D.
Diplomat American Board of Orthopaedic Surgery
advanced arthroscopy | shoulder surgery | trauma | QME

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As require by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordination, or managing health care and related services by one or more health care providers *an example of this would include teeth cleaning services.*
- Payment means such activities as obtaining, reimbursement for services, confirming coverage, billing, or collections activities and utilization review *an example of this would be sending out a bill for your visit to your insurance company for payment.*
- Health care operations include the business aspects of running our practice such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service *an example of this would be an internal quality assessment review.*

We may also create and distribute the identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and service that may be of interest to you.

Any other uses and disclosures will be made with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following right with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restriction on certain uses and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request

We are require by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is affected as of April 14, 2003 and we are required to abide by the terms of Notice of Privacy Practices currently in affect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions affective for all protected health information that we maintain. We will post and you may request a copy of the revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protection has been violated. You have the right to file written complaints with our office, or with the Department of Health and Human Services, Office of Civil Rights about violations of the provisions of this notice or policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information at the address below. For more information about HIPAA or to file a complaint:

The US Department of Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington D.C., 20201
(202) 619- 0257; Toll free: (877) 696-6775

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of this medical practice's *Notice of Privacy Practices.* I further acknowledge that copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended *Notice of Privacy Practices* at each appointment.

Signed: _____ **Date:** _____

Print Name: _____

If not signed by the patient, please indicate relationship:

Name of patient: _____

Relationship to patient: _____

GLENDALE | PALMDALE | KOREATOWN
435 Arden Avenue, Suite 530, Glendale, CA 91203 | Telephone. 818.550.9910 | Facsimile. 818.550.9901
1037 E. Palmdale Boulevard, Suite 202, Palmdale, CA 93550 | Telephone. 661.456.3177 | Facsimile. 661.266.1373
1035 S. Vermont Avenue, Los Angeles, CA 90006 | Telephone. 213.387.0102 | Facsimile. 213.738.8764

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PATIENT DEMOGRAPHIC INFORMATION

NAME (환자이름): _____

DATE OF BIRTH (생년월일): ____/____/____

GENDER(성별): M (남) F (여)

SOCIAL SECURITY NUMBER (소셜시큐리티넘버): ____-____-____

MARITAL STATUS (혼인여부):
Married (기혼) Single (미혼) Divorced (이혼) Widowed (과부)

OCCUPATION: _____

EMPLOYER: _____

HOME ADDRESS(주소): _____

CITY (도시): _____ **STATE** (주)**:** _____ **ZIP**(우편번호)**:** _____

HOME PHONE (전화번호): _____

MOBILE: _____ **WORK NUMBER**: _____

EMAIL ADDRESS: _____

PREFERRED PHARMACY (약국이름): _____

ADDRESS: _____ **CITY:** _____

PHONE NUMBER: _____

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MEDICAL HISTORY

DUE TO NEW HEALTHCARE REGULATIONS, WE ARE REQUIRED TO REQUEST ETHNICITY AND RACE INFORMATION AS PART OF YOUR MEDICAL RECORD.

ETHNICITY(민족): Hispanic(히스패닉) Non-Hispanic(비히스패닉)
Decline (대답거부)

LANGUAGE PREFERENCE (선호하는 언어): _____

HEIGHT (신장): _____ ft. _____ in. **WEIGHT** (체중): _____ lbs.

ANY ALLERGIES TO MEDICATIONS (약에 대한 알러지 여부):

_____

CURRENT MEDICATIONS (현재 복용중인 약):

_____ _____ _____

_____ _____ _____

PREVIOUS SURGERIES (수술 기록):

TYPE: _____ **DATE(날짜):** _____

_____ _____

_____ _____

FAMILY HISTORY OF ILLNESSES / DISEASES (가족병력):

_____

DO YOU SMOKE? (흡연 여부): Yes (예) No (아니오) If so, how many cigarettes / packs per day (흡연 하신다면 몇 개/갑을 피십니까) ?

_____

DO YOU DRINK ALCOHOL? (음주 여부): Yes (예) No (아니오) If so, how much alcohol do you consume per week? (음주 하신다면 일주일에 얼마 정도 하십니까?

_____

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FEMALE PATIENTS ONLY (여성 환자분)

IS IT POSSIBLE THAT YOU MAY BE PREGNANT? (현재 임신 중이거나 임신 가능성이 있습니까?)

YES (예) NO (아니오)

ARE YOU CURRENTLY BREASTFEEDING? (현재 모유수유중이십니까?)

YES (예) NO (아니오)

ARE YOU CURRENTLY ON BIRTH CONTROL PILLS? (현재 피임약 복용 중이십니까?)

YES (예) NO (아니오)

I UNDERSTAND THAT ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH MEDICAL CARE IN A SAFE AND EFFICIENT MANNER. I HAVE ANSWERED ALL QUESTIONS TO THE BEST OF MY KNOWLEDGE. SHOULD FURTHER INFORMATION BE NEEDED, YOU HAVE MY PERMISSION TO ASK THE RESPECTIVE HEALTHCARE PROVIDER OR AGENCY, WHO MAY RELEASE SUCH INFORMATION TO YOU. I WILL NOTIFY THE DOCTOR OF ANY CHANGE IN MY HEALTH OR MEDICATION.

저는 위의 정보가 안전하고 효율적인 방법으로 의료 정보를 제공하기 위해 필요하다는 것을 인정합니다. 저는 저의 지식 안에서 최선을 다해 모든 질문에 대답하였습니다. 더 자세한 정보가 필요하다면 의료제공 기관에 의뢰하실 수 있습니다. 저의 건강상태나 복용약에 대해 변경사항이 있다면 의사 선생님께 알려드리겠습니다.

PATIENT SIGNATURE: _____ DATE: _____

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INSURANCE INFORMATION

NAME OF INSURANCE: _____

NAME OF POLICY HOLDER: _____

DATE OF BIRTH OF POLICY HOLDER: _____

OR

□ **NO INSURANCE**

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS FOR SERVICES RENDERED AND REQUEST PAYMENT OF BENEFITS TO THE OFFICE. I FULLY UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT FOR ALL SERVICES RENDERED BY LEE ORTHOPAEDIC INSTITUTE, REGARDLESS OF INSURANCE COVERAGE.

나는 나에게 제공된 의료 서비스 관련 금액 지불 요청 및 보험 혜택 절차를 밟는 과정에 필요한 모든 의료 정보 공개를 승인합니다. 나는 "이 정형외과" 에서 받은 모든 서비스에 대한 보험 적용범위는 궁극적으로 나에게 모든 책임이 있음을 인정합니다.

Sign: _____

Date: _____

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ASSIGNMENT OF BENEFITS
RELEASE OF MEDICAL INFORMATION
PAYMENT AGREEMENT

I request and authorize that all insurance benefits of Medicare, Medi-cal, and/or private insurance be paid on my behalf to "Lee Orthopaedic Institute". This is for all services furnished to me by Lee Orthopaedic Institute. This "*Assignment of Benefits"* is to remain in effect until revoked by me in writing. A photocopy of this statement shall be considered valid as the original.

I further authorize Lee Orthopaedic Institute to release any and all medical information necessary to process my claim and to secure payment.

I understand that I am responsible for any and all charges NOT covered by my insurance, including any deductible and/ or any copayments.

I understand that Lee Orthopaedic Institute does not refund, exchange, discount, or make price adjustments for services previously rendered, regardless of change in insurance status.

If, for any reason, insurance is not present, unable to be verified, or is ineligible, the set fee for services provided must be paid at time of service. This fee schedule is mutually agreed upon and is non-refundable.

Lee Orthopaedic Institute will make every effort to assist you, our patient, in understanding the scope of your insurance benefits and the method of determining your coverage. Nevertheless, it is ultimately your responsibility to understand your policy, its benefits, and the obligations it places on you. It is not the responsibility of LEE ORTHOPAEDIC INSTITUTE to verify your insurance coverage (this includes information as far as our physicians' in or out of network status) or determine which services are or are not covered. Additionally, it is your responsibility to ensure that laboratory tests, X-rays, and consultations are covered by your insurance. Therefore, if your insurance denies payment for any reason, the amount is your responsibility and must be paid promptly.

I have read and understood the above information and accept full responsibility if my insurance does not pay for services rendered including any deductible and/ or copayments.

Sign: _____

Date: _____