Welcome to our office

Dear Patient,

The goal of our entire staff is to be of service to you. We want to help you to be as healthy as possible. We will work together to strive to achieve your health care goals. We want you to have a medical home in which you feel comfortable and both cared for and cared about. We truly love and care about each one of our patients.

Good health care is provided in the context of a mutually trusting, honest and kind relationship.

We want everyone who is a part of our medical family to understand the principles under which we function.

Our physicians and office staff will work together to provide you with the health care you need in a timely manner. You should plan on scheduling your yearly health maintenance exam about four months ahead of when it is due. We manage our schedule so that when you have an urgent or acute need, we can see you. We promise to be responsible in scheduling in such a way to allow you access to the health care you need and with respect for your time.

We will respect your privacy and will hold your medical information for you confidentially. Your records and medical history are not shared with anyone without your written permission unless required by law.

We will be honest with you in all aspects of your health care.

Our physicians will maintain both their medical knowledge and their skills so that they can offer you the best health care. We will listen to you and always put your insight foremost in our decision-making process. We will provide you with as much information as we can in respect to your health care.

We will offer optimal health care in the most cost-effective way possible without compromising our mutual goals.

It has been obvious to us through the years that our patients want to know how to best partner with us, your health care providers.

The most important role of our patients may seem self-evident. It is to be honest and open with us. The better the information we get from you, the better we can serve you. We rely on the history you give us to make medical decisions. Be as complete as possible. If you have outside medical records, collect them and bring them in. Making a list of your medical questions and bringing it to each appointment can be extremely helpful. Let us know if you need prescription refills. Please do not hesitate to be completely honest with us. We won't discipline or judge you.

Patients sometimes ask us to make medical diagnoses and recommendations on the phone. This is almost uniformly a bad idea. We want to make the best possible medical decisions with you. Please know that it is because of this that we ask you to make an appointment and come in.

It is our office policy that we do not fill prescriptions for controlled substances such as narcotics, ADD medications and benzodiazepines without an appointment. Again, this allows us to look for side effects and to be sure you are receiving the best medications for your conditions.

Unless otherwise arranged with your physicians, you can expect us to send you any results of tests or labs within two weeks. If you do not receive these, please call our office.

Should you have an emergent need outside of office hours, you can reach your physician on their cell phone. They also provide their emails for simple medical questions and as a means of mutually agreed on communication. Prescription refills are best handled at your appointments. Should you unexpectedly run low on a medication (other than a controlled substance) you can call the office providing a full day for your pharmacy and physician to get that filled for you. We do require that you be seen at least once a year for medications to be filled over the phone.

Daily Urgent Appointments

Our office reserves availability each day for urgent appointments. If patients feel like they need to be seen for an urgent appointment, try to call us at our office opening time, which is 8:00 am, to claim an appointment for that day. If there is a question to whether a patient needs an urgent appointment, or if they can wait until the next appointment opening, please contact us to discuss. If a patient needs to be seen on the weekend, but does not think it's an emergency, then reach out to your primary care physician via cell phone, text or email, preferably before going to an urgent care. Patients may get their contact information at their first new patient appointment.

Cancellation of an Appointment

Our goal is to provide quality medical care to patients in need. We will call you two days before your appointment as a courtesy reminder. We ask that you call us a day ahead of time if you cannot make your appointments. This allows us to give that time to another patient who needs it.

Missing an Appointment

Our office understands that emergencies do occur in our daily lives, and sometimes cannot be avoided. Please contact us as soon as possible if you are going to miss a same-day appointment. If the patient does not contact us, we will have to charge accordingly with the information below. If the patient does call us, this fee may be waived, depending upon the circumstances. If a patient has multiple same-day cancellations, this may be grounds for discharging the patient from our practice.

Missed 15-minute appointment: $25
Missed 30-minute appointment: $50
Missed 45-minute appointment: $75
Missed Annual and/or Physical Appointments: $100

Please don't hesitate to call the office should you have questions or concerns. We look forward to seeing you at your appointment.

Sincerely,

Dr. Rebecca Patrias, Dr. Sarah Bur, Dr. Lynn Kriengkrairut,
and the Staff of Three Chelsea Docs

Quality Care With a Personal Touch
350 N. Main Street, Suite #100
Chelsea, MI
Office: 734-433-1500
Fax: 734-433-1400

Name _____ Date of Birth _____ Sex _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Email Address _____

Social Security Number _____ Marital Status _____

Employer _____ Occupation _____

Work Phone _____

Primary Insurance _____

Contract Number _____ Group # _____

Relationship to Primary Insurance Member
(Circle One)

Self Spouse/Partner Child/Dependent

Primary Card Holder's Full Name _____ DOB _____

Secondary Insurance _____

Contract Number _____ Group # _____

Relationship to Primary Insurance Member
(Circle One)

Self Spouse/Partner Child/Dependent

Secondary Card Holder's Full Name: _____ DOB _____

Emergency Contact _____ Phone _____

I agree that the above information is correct. I hereby authorize the release of medical information to insurance carriers concerning my illness and treatment and I hereby assign to the doctor all payments for medical services rendered.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE

Signature _____ Date _____

Dr. Rebecca Patrias, Dr. Sarah Bur, and Dr. Lynn Kriengkrairut
350 N. Main Street, Suite #100, Chelsea, MI 48118

MEDICAL HISTORY FORM

Name: _____ DOB: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Work: _____

Email: _____ Marital Status: _____

Employer: _____ Job: _____

Education Level: _____ Preferred Pharmacy: _____

Emergency Contact: _____ Emergency Contact Phone: _____

FAMILY MEDICAL HISTORY				
	Yourself	Father	Mother	Siblings
High Blood Pressure				
High Cholesterol				
Diabetes				
Heart Disease/Heart Attack				
Cancer				
Lung Disease (Asthma/COPD)				
Thyroid Disease				
Autoimmune Disease				
Stroke				
Osteoporosis				
Alcoholism/Addiction				
Depression or Psychiatric Disease				
Other (specify):				
Check if Deceased >				

Medications and Dosages (including vitamins/herbs):

_____
_____
_____
_____
_____
_____
_____
_____

Specialists:

_____
_____
_____
_____
_____
_____
_____
_____

Drug Allergies: _____

Operations and Past Hospitalizations: _____

_____
_____
_____
_____
_____

Health History / Review of Systems

Name: _____ DOB: _____ Date: _____

Exercise: Type _____ Min: _____ Per: Day / Week

Sleep: _____ hrs/night Seat belt: Y/N Tobacco/Nicotine: _____ /day Start? _____ Quit? _____

Alcohol: _____ drinks/wk Recreational drugs: _____

Date of last: Tetanus shot: _____ Pneumonia shot: _____ Shingles shot: _____

CURRENT MEDICAL CONCERNS: _____

_____

PLEASE CHECK ALL THAT APPLY (current or recent symptoms)

- ☐ weight gain
- ☐ weight loss
- ☐ fatigue
- ☐ fever
- ☐ night sweats

- ☐ visual difficulties
- ☐ hearing difficulties
- ☐ ear pain
- ☐ seasonal allergies
- ☐ dental problems

- ☐ chest discomfort
- ☐ rapid or irregular heartbeat
- ☐ swelling in feet/legs

- ☐ cough
- ☐ wheezing
- ☐ shortness of breath
- ☐ snoring
- ☐ sleep apnea

- ☐ nausea
- ☐ vomiting
- ☐ diarrhea
- ☐ constipation
- ☐ abdominal pain
- ☐ change in stool
- ☐ blood in stool
- ☐ reflux/heartburn
- ☐ last colonoscopy/sigmoidoscopy:

  _____

- ☐ new/changed headache
- ☐ seizure
- ☐ dizziness
- ☐ passing out
- ☐ numbness/tingling
- ☐ tremor/shakiness
- ☐ memory loss
- ☐ weakness

- ☐ easy bruising/bleeding
- ☐ swollen lymph nodes
- ☐ blood clot

- ☐ rash
- ☐ worrisome moles

MEN:

- ☐ penile discharge
- ☐ weakness of urinary stream
- ☐ nighttime urination
- ☐ number of children _____

WOMEN:

- ☐ pregnancies _____
- ☐ number of children _____
- ☐ number of miscarriages _____
- ☐ number of abortions _____
- ☐ painful/heavy periods
- ☐ irregular periods
- ☐ last mammogram _____
- ☐ last PAP _____
- ☐ menopausal symptoms
- ☐ breast lumps
- ☐ date of last period _____

- ☐ muscle pain
- ☐ joint pain

- ☐ gender identity _____
- ☐ sexual orientation _____

- ☐ urinary incontinence
- ☐ painful urination
- ☐ urinary urge/frequency
- ☐ blood in urine
- ☐ sexual difficulties/concerns

- ☐ suicidal thoughts
- ☐ increased stress
- ☐ difficulty sleeping
- ☐ anxiety/nervousness
- ☐ family/marital issues
- ☐ pushed/shoved/harmed
- ☐ domestic violence
- ☐ eating disorder (past or present)

- ☐ advanced directive
- ☐ living will
- ☐ power of attorney

Personal goals for the upcoming year: _____

_____

Name: _____ DOB: _____

Social Needs Screening Form

		Yes / No
	In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?	Y N
	In the last 12 months, has the electric, gas, oil, or water company threatened to shut off your services in your home?	Y N
	Are you worried that in the next 2 months, you may not have stable housing?	Y N
	Do problems getting child care make it difficult for you to work or study? *(leave blank if you do not have children at home.)*	Y N
$	In the last 12 months, have you needed to see a doctor, but could not because of cost?	Y N
	In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?	Y N
	Do you ever need help reading hospital materials?	Y N
	Do you often feel that you lack companionship?	Y N
!	**Are any of your needs urgent?** For example: I don't have food for tonight, I don't have a place to sleep tonight.	Y N
?	If you checked YES to any boxes above, would you like to receive assistance with any of these needs?	Y N

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns _____ + _____ + _____

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: _____

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

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A2663B 10-04-2005

Notice of Privacy Practices

As required by the Health Insurance Portability and Accountability Act of 1966 (HIPAA)

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

Your medical information is personal, and we are committed to protecting your privacy. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your medical information and what rights you have regarding information. If you have any questions, please contact the division contact shown above.

We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all your records that our practice has created or maintained and for any generated in the future. Our practice will post a copy of our current notice in our offices in a visible location and you may request a copy of our most current notice at any time.

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following categories describe the ways in which we may use and disclose your medical information. We routinely use your medical information inside our office for these purposes without any special permission. For clarification, we have included some examples. Not every possibility is specifically mentioned. However, all the ways we are permitted to use and disclose your medical information will fit within one of these general categories.

Treatment. Our practice may use and disclose your medical information to treat you. Common reasons for use and disclosure may include performing exams, ordering or performing tests, ordering prescriptions, referring you to other medical professionals, or obtaining copies of information from your other providers. Additionally, we may disclose your medical information to others who may assist in your care, such as your spouse, children or parents.

Payment. We may use and disclose your medical information in order to bill and collect payment for services. For example, we may provide your insurer with treatment information to certify eligibility. We may use and disclose your medical information to obtain payment from third parties that may be responsible for costs, such as family members.

Health Care Operations. Our practice may use and disclose your medical information to operate our business. Examples may include using your medical information to evaluate the quality of care you received from us or to conduct cost-management and business planning activities for our practices.

Appointment Reminders. Our practice may use and disclose your medical information to contact you and remind you of an appointment.

Treatment Options and Health-Related Benefits. Our practice may use and disclose your medical information to inform you of potential treatment options or health-related benefits or services that may be of interest to you.

Disclosures Required by Law. Our practice will use and disclose your medical information when we are required to do so by federal, state or local law. For example, disclosure may be required by Workers' Compensation statutes and various public health statues in connection with required reporting of births and deaths, certain diseases, child abuse and neglect, domestic violence, adverse drug reactions, etc.

Health Oversight Activities. Our practice may disclose your medical information to a health oversight agency for activities authorized by law. Oversight activities can include investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

Lawsuits and Similar Proceedings. If you are involved in a lawsuit or similar proceeding, we may use and disclose your medical information in response to a court or administrative order or to defend the office. We also may disclose your information in response to a discovery request, subpoena, or other lawful process by another party involved, but only if we have tried to inform you of the request or to obtain an order protecting the information the party has required.

Law Enforcement and/or National Security. We may disclose your medical information for law enforcement purposes. For example, we may provide information about someone who is or is suspected to be a victim of a crime, to provide information about a crime at our office, or to report a crime that has happened elsewhere. Further, we may disclose your medical information to federal officials for intelligence and national security activities authorized by law, including to protect the President or other officials including foreign heads of state, to conduct investigations, or for military purposes.

Deceased Patients. Our practice may release medical information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information for funeral directors to perform their jobs or, when requested, to facilitate organ, eye or tissue donation.

Research. Under certain circumstances, we may use and disclose your medical information for health-related research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition.

Serious Threats to Health or Safety. Our practice may use and disclose your medical information to prevent a serious threat to your health and safety or the health and safety or another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Incidental Disclosures. Our practice may disclose your medical information if it is an unavoidable byproduct of conducting business, including receiving services from cleaning personnel and those maintaining or repairing equipment.

Business Associates. Our practice may disclose your medical information to business associates who perform health care operations for us and who commit to respect the privacy of your health information.

Other uses and disclosures of your medical information not covered by this notice will be made only with your written authorization. If you provide us such an authorization, you may revoke it, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your information for the reasons covered by the authorization.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding the medical information that we maintain about you:

Confidential Communications. You have the right to request that we communicate with you in a particular manner. For instance, you may ask that we contact you at home rather than work. To request a type of communication, you must make a written request. We will accommodate reasonable requests.

Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your medical information for treatment (except in emergencies or when required by law), payment, or health care operations. We are not required to agree to your request; if we do agree, we are bound by our agreement. You also have the right to request that we restrict our disclosures of your medical information to only certain individuals involved in your care. To request a restriction, you must make a written request.

Inspection and Copies. You have the right to see and copy your medical information. Our practice may charge a fee for the costs of copying and mailing your information. By law, our practice may deny your request to see and/or copy your information in certain limited circumstances; however, you may request a review of our denial. To see or obtain copies of your medical information or for information regarding a denial review, please submit a written request.

Amendment. If you feel that the medical information we have about you is incorrect and/or incomplete, you may send us a written request to amend the information. The request must include a reason supporting your request. We may deny your request if it is not in writing or does not include a reason. Further, we may deny your request if you ask us to amend information that is, in our opinion, accurate and/or complete, not part of the information kept by us, not part of the medical information which you would be permitted to see and copy, or if it was not created by us.

List of Disclosures. You have a right to request a list of disclosures our practice has made of your medical information for non-treatment, non-payment or non-operations purposes. Use of your medical information as part of the routine patient care in our practices is not required to be documented and, therefore, will not be on the list. Further, the list will not include disclosures made with your authorization, incidental disclosures or those required by law. In order to obtain a list of disclosures, you must submit your request in writing. All requests must state a time period (not to exceed six years) and may not include dates before April 14, 2003. You are entitled to one such list per year free of charge; additional lists may require payment.

Right to a Paper Copy of This Notice. You are entitled to receive additional copies of this notice of privacy practices at any time. To obtain a copy of this notice, please submit a written request.

File a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practices or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, please submit it in writing. This office will not penalize you in any way for submitting a complaint.

NOTICE OF PRIVACY PRACTICES

HIPAA

Dr. Patrias, Dr. Bur, and Dr. Lynn Kriengkrairut must collect timely and accurate health information about you and make that information available to members of your health care team in this agency so that they can accurately diagnose your condition and provide the care that you need. There may also be times when your health information will be sent to service providers outside this agency for services that this agency cannot provide. It is the legal duties of Dr. Patrias, Dr. Bur, and Dr. Lynn Kriengkrairut to protect your health information from unauthorized use or disclosure while providing health care, obtaining payment for that health care and for other services relating to your health care.

The purpose of this *Notice of Privacy Practices* is to inform you about how your health information may be used with the practice of Dr. Patrias, Dr. Bur, and Dr. Lynn Kriengkrairut as well as reasons why your health information could be sent to other service providers outside of this agency.

This *Notice* describes your rights in regard to the protection of your health information and how you may exercise those rights. This *Notice* also gives you the names of contacts should you have questions or comments about the policies and procedures Dr. Patrias, Dr. Bur, and Dr. Lynn Kriengkrairut use to protect the privacy of your health information.

Please review this document carefully and ask for clarification if you do not understand any portion of it.

Patient Acknowledgment

I have received a copy of *Notice of Privacy Practices*, which describes this agency's methods for protecting the privacy of my health information that is used in providing heath care services to me.

_____

Patient Name (please print)

_____ _____

Signature Date

Please list below individuals you authorize us to discuss your care with:

_____

_____

Note: Office retains this signed page.
Client retains the Notice of Privacy Practices document.

MEDICAL RELEASE OF INFORMATION/REQUEST FOR MEDICAL RECORDS

INFORMATION TO BE DISCLOSED

I authorize (previous doctor) _____, (city) _____, (state) _____, (phone number) _____, its agents and its employees to release protected health information about me to Dr. Rebecca Patrias, Dr. Sarah Bur, and Dr. Lynn Kriengkrairut. This may include alcohol and/or drug abuse treatment, psychological and social work counseling, communicable disease or infections including sexually transmitted diseases, venereal disease, tuberculosis and hepatitis, and demographic information for the purposes and under the conditions designed on this form.

Date of Request: _____ (this request is good for one year from the date of request)

Patient: _____

Address: _____

City/State/Zip: _____

DOB: _____

I _____, give my permission for the release of health information.

***Please include:

- Problem Summary List
- Most recent Laboratory tests plus PAP
- Consultation (referral) notes for the last year plus any colonoscopy reports
- X-ray reports for the last two years, plus most recent mammogram
- Other (please specify): _____

Please mail or fax immediately to:

Dr. Rebecca Patrias, Dr. Sarah Bur, and Dr. Lynn Kriengkrairut
350 N Main St Ste #100 Chelsea, MI 48118
Office: 734-433-1500 Fax 734-433-1400

Revocation: I understand that I may revoke my authorization. After it is revoked, the doctors will make no further disclosures to the above-mentioned persons without a new authorization. In the event that the authorization was obtained as a condition of providing insurance coverage, the authorization will not apply to my insurance company to the extent that the law provides my insurer with the right to contest a claim under the policy, or the policy itself.

Re-disclosure: Once information has been disclosed, it may no longer be protected from further disclosure by federal or state privacy laws.

Conditioning of Eligibility: The doctors will not condition treatment, payment or eligibility on my signing this document.

Signature: _____ Date: _____

Please MAIL records if over 50 pages*