Name ______________________________ Date ______________

Reason for Visit:
- □ Follow-up
- □ New Patient
- □ Injection

Any changes in your insurance or contact information?
Yes No

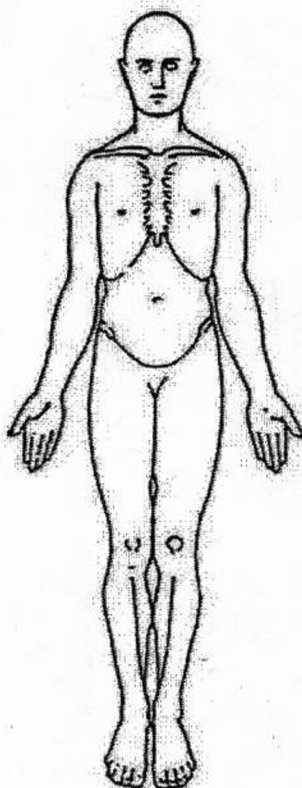
Are there any changes in your medication?
- □ Yes
- □ No

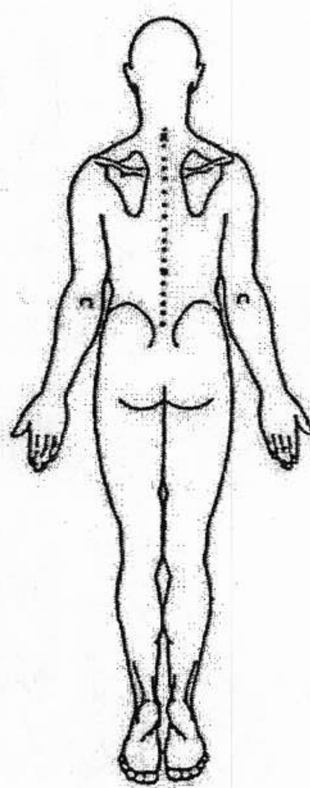
Please describe your pain:

Intensity ______/10
Throbbing Aching Burning Shooting Stabbing
How Often? Please circle: continuous or intermittent
Increased by ____________________

Please circle all that apply:
- □ Weight gain
- □ Loss of appetite

Decreased by ____________________
- □ Recent fever
- □ Weakness in : arms legs body
- □ Weight loss
- □ Fatigue
- □ Insomnia
- □ Cramps in: legs muscles
- □ Joints : pain swelling stiffness surgery
- □ Recent headache
- □ Tingling or numbness in: arms legs
- □ Seizures
- □ Memory loss
- □ Tremors
- □ Dizziness
- □ Loss of feeling in: arms legs body
- □ Nausea Vomiting
- □ Recent rash
- □ Frequent/easy bruising
- □ Chest pain
- □ Shortness of breath
- □ Irregular heartbeat
- □ Changes in bowel bladder functions
- □ Reflux or heartburn
- □ High stress level
- □ Eating disorders
- □ Bleeding Issues





Do you need any medications refills this visit? If so please list.

FOR STAFF USE ONLY Revised 10/28/19

Temp ____________ Xray/ MRI ____________________
Height ____________ ____________________ Any new medical issues? _____
Weight ____________ Labs ____________________ ____________________
BP ____________ Any changes to medication? ______ ____________________
Pulse ____________ ____________________

BENJAMIN LEE, M.D.
PATIENT INSURANCE FORM

Patient Name: ______________________ Age: ______ Date of Birth: __________
Address: ______________________ City/State/zip: __________________
Home Phone: ______________________ Social Security #: ________________
Marital Status: Single _____ Married: _____ Other: ________ Gender: Male ______ Female: ______
Employer: ______________________ Work Phone #: __________________
Spouse/Parent Name (if under 18): ______________________
Address (if different from above): ______________________
Referring Physician: ______________________ Primary Care Physician: __________

INSURANCE INFORMATION

Primary Insurance
(Please check one)
___Health Insurance
___Auto Accident
___Workman's Comp
___Other

Policy holder: ______________________ Self, Spouse, Parent, Other
Company Name: ______________________
Address: ______________________
Adjustor: ______________________ Phone #: ______________
ID#: ______________________ Group #: ______________
Policy #: ______________________ Claim #: ______________

Secondary Insurance
(Please check one)
___Health Insurance
___Auto Accident
___Workman's Comp
___Other

Policy holder: ______________________ Self, Spouse, Parent, Other
Company Name: ______________________
Address: ______________________
Adjustor: ______________________ Phone #: ______________
ID#: ______________________ Group #: ______________
Policy #: ______________________ Claim #: ______________

Date of Injury: ________
Insured Name and DOB (if other than patient) ______________________
Do you have an attorney? __
Attorney Name: ______________________
Phone #: ______________________

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS
PLEASE READ CAREFULLY AND SIGN BELOW

I hereby authorize Benjamin Lee, M.D. to furnish information to my insurance carriers concerning my illness/injury and treatment. I hereby assign Benjamin Lee, M.D. any and all payments for medical services rendered to myself and/or dependents. I understand that I am responsible for any amount not covered by my insurance. I also understand that if my account is turned over to a collection agency and/or legal counsel, I will be responsible for any collection and/or legal fees incurred in addition to the office charges.

SIGNATURE: ______________________ DATE: ____________

WORKMAN'S COMP AUTHORIZATION

I authorize the release of medical information regarding my work injury sustained on ____________ to my employer ______________________

SIGNATURE: ______________________ DATE: ____________

Benjamin Lee, MD
Pain Management Consultant
2012 S. Tollgate Rd, Suite 111
Bel Air, Maryland 21015
Phone: 443-490-4000
Fax: 443-484-2831

Photo Consent Form

I authorize Chesapeake Pain Management Center to obtain my photograph for medical records purposes. This photograph will be attached to my electronic patient chart and assists in identifying and preventing others from fraudulent use.

____

Patient Signature   Date

____

Witness Signature   Date

Chesapeake Pain Center

Benjamin Lee, MD
2012 South Tollgate Road
Suite 111
Bel Air, MD 21015
(P) 443-490-4000
(F) 443-484-2831

CONDITIONS FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

By entering this practice and agreeing to receive services, I understand and agree to the following:

- I am responsible for my DEA controlled medications. If the prescription of medication is lost, misplaced, stolen, or if I take them more than as directed and run out early, I understand that the prescription may not be replaced.
- If I see another physician who prescribes me DEA controlled medications, I will inform him/her of my current prescription from Chesapeake Pain Center, including my dosage, number of pills on hand, and date(s) obtained.
- I will inform Chesapeake Pain Center about DEA controlled medications prescribed to me by other providers, including dosage, number of pills on hand, and date(s) obtained.
- I agree to obtain my DEA controlled medications from one pharmacy.
- I will cooperate with the treatment plan for my condition and pain management.
- I will not use illicit (illegal) substances while under the care of the Chesapeake Pain Center.
- I will agree to and cooperate with random drug screens and pill counts.
- I agree to Chesapeake Pain Center obtaining my pharmacy profile as necessary from my issuing pharmacy.
- I consent to communication between Chesapeake Pain Center staff and my pharmacist. I also consent to the release of my pharmacy medication profile to the Chesapeake Pain Center office.
- I agree to not give away or sell any of my DEA controlled medications.

I, ______________________________, DOB: ________________, enter into this agreement with a full understanding of all of the above, as well as the side effect profile of DEA controlled medications. This includes, but is not limited to, dependency, tolerance, addiction and death. I understand this agreement will be periodically reviewed to reflect my current medical status.

I understand if there is a breach of this contract, my care at Chesapeake Pain Center may be terminated.

______________________________ ______________________________
Patient Signature Date

Chesapeake Pain Center

2012 S. Tollgate Rd, Suite 111
Bel Air, MD 21015
(P) 443-490-4000
(F) 443-484-2831

ADVANCED DIRECTIVES

Advanced Directives are statements that indicate the type of medical treatment wanted or not wanted in the event you are unable to make those decisions, and who is authorized to make those decisions. The two most common forms of advance directive are Living Wills and Durable Power of Attorney.

The physicians and staff at Chesapeake Pain Center value your right to make informed decisions regarding your healthcare. Pain management procedures performed at Chesapeake Pain Center, LLC are elective in nature and expected to be short duration. Adverse incidents during procedures are not expected. Taking this into consideration, your advanced healthcare directive will NOT be honored by Chesapeake Pain Center, but instead, life threatening measures will be provided until such time the patient can be transferred to the nearest hospital. A copy of your advanced healthcare directive, if provided upon admission to our facility, will be included with your medical records in the event of an unexpected transfer.

Please Initial:

_________I have read and understand the Advanced Directive policy and procedures of Chesapeake Pain Center as stated above.

Please Initial ONE of the lines below that pertains to your situation:

_________ I **HAVE** executed an Advanced Directive and have provided it to this office.

OR

_________ I have **NOT** executed an Advanced Directive.

OR

_________ I **HAVE** executed an Advanced Directive but have **NOT** provided a copy to this office.

_______________________________ _______________
Patient Name Printed Patient DOB

_______________________________ _______________
Patient Signature Date

Benjamin Lee, MD

2012 South Tollgate Road, Suite 111

Bel Air, MD 21015

(P) 443-490-4000 (F) 443-484-2831

Dear Patient:

Thank you for scheduling your appointment at the office of Benjamin Lee in Bel Air, MD. Dr. Lee has designed his office with his patients in mind, and we are proud to serve you here.

Although Dr. Lee may be a participating provider with your insurance plan, sometimes he may not be. If you have any questions, please do not hesitate to consult with our billing department.

At times, your insurance company may send payment directly to you, as the guarantor for reimbursement for services rendered by Benjamin Lee, MD. By signing this agreement, you are agreeing to forward the payment along with a copy of the EOB (Explanation of Benefits), to Benjamin Lee as soon as payment is received.

Failure to provide us with the payment made by your insurance carrier, on your behalf, for your procedure, could result in the following actions:

(Please initial each line below)

_______ May be reported to the proper authorities as insurance fraud and/or theft.
Initials

_______ Can be reported to the IRS as income received.
Initials

_______ Any balance for services provided by Benjamin Lee, MD will be billed to you directly.
Initials

(Please sign and date below)

_______________________________ _______________
Patient Signature Date

_______________________________ _______________
Guarantor Signature (if not patient) Date

_______________________________ _______________
Print Name Date

Revised 3/18/20

Benjamin Lee, MD
2012 South Tollgate Road
Suite 111
Bel Air, MD 21015
443-490-4000 (P) 443-484-2831 (F)

Patient Financial Liability Form

Insurance will be accepted under the following conditions:

The information that you provide is accurate and current. Any changes in coverage or policy are your responsibility. Should you have a change in coverage or policy, you must notify us prior to your next appointment so that we can make sure you receive the proper insurance coverage. All co-payments are due at the time of service. The patient will be responsible to pay any deductibles and coinsurance that apply within 30 days from determination by your insurance carrier or at your next visit, whichever comes first. Should the insurance company deem any service as "patient liability", you will be held responsible for that service. All outstanding patient balances are to be paid before another session with Dr. Benjamin Lee will occur. For your convenience, we accept cash, checks (accompanied by a valid state identification), VISA, and MASTERCARD.

Patients are fully responsible for obtaining a referral from their primary care physician should one be required, and any service denied for lack of referral will be your responsibility. Benjamin Lee makes every effort to obtain accurate information from your insurance carrier, however, a verification of benefits is NOT A GUARANTEE OF PAYMENT. The insurance carrier makes the final determination of payment and who is to be held liable for the claim balance.

We bill the insurance companies that we participate with; however, if we are not paid in a timely fashion, you will be responsible for the bill and expected to pay in full before your next visit. Please note that although we participate with certain insurance plans, some charges may not be covered under those plans (co-payments, medical equipment, and supplies etc.) Except as provided by such contract or state law, we will hold you responsible for all charges not paid by your insurance carrier.

I hereby authorize Benjamin Lee to furnish information to my insurance carriers concerning my illness/injury and treatment. I hereby assign Benjamin Lee all payments for medical services rendered to myself and/or dependents. In the event that my insurance company sends payment/check for services rendered to me and not to Benjamin Lee, I ______________________________,

agree to submit payment or sign the check over to Benjamin Lee within 30 days. I understand that I am responsible for any amount not covered by my insurance. I also understand that if my account is turned over to a collection agency and/or legal counsel, I will be responsible for any collection and/or legal fees and compound annual interest at 17% for balances past 90 days delinquent.

SIGNATURE:______________________________ **DATE:**______________

PRINTED NAME:______________________________ **DATE:**______________

UPDATED 3/6/20

Benjamin Lee, MD

2012 South Tollgate Road, Suite 111

Bel Air, MD 21015

(P) 443-490-4000 (F) 443-484-2831

Rights and Responsibilities Agreement Form

I have received and read a copy of Benjamin Lee's Rights and Responsibilities Form and I agree to abide by my responsibilities as a patient and expect my rights to be met.

Signature ______________________ Date ______________

Privacy Policy Statement Agreement Form

I have received and read a copy of Benjamin Lee's Privacy Policy Statement.

Signature ______________________ Date ______________

Disclosure of Physician Ownership Notice to Patients

Please carefully review the information contained in this notice.

1. Benjamin Lee, MD is an owner of Benjamin Lee of Bel Air.
2. You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than Benjamin Lee.
3. Your physician will not treat you differently if you choose to obtain health care services at a facility other than Benjamin Lee.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of Benjamin Lee. We welcome you as a patient and value our relationship with you.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Benjamin Lee.

Signature ______________________ Date ______________

Revised 3/18/20

Benjamin Lee, MD Pain Questionnaire

Please completely fill out the following information. All questions are pertinent in order to provide you with comprehensive care.

GENERAL INFORMATION

Name:______________________ Today's Date:______________________

Address:______________________ Date of Birth:______________________

______________________ Sex:______________________

Home Phone: (_____)______________________ Cell Phone:______________________

Work Phone: (_____)______________________ Email:______________________

Primary Care Physician:______________________ PCP Phone# ______________________

Emergency Contact:______________________ E.C. Phone#______________________

E.C. Relationship:______________________ Highest Level of Education:______________________

Language Spoken:______________________ Interpreter Needed: YES / NO

Please list all who currently live in your household:______________________

____

Are there any cultural, religious, social or financial concerns that we should know about in order to better meet your needs? ______________________

COMPENSATION AND LEGAL INFORMATION

1. Are you currently receiving compensation or disability payments? ______________________

   If yes, are the payments adequate?______________________

2. Do you have an application for compensation or disability payments pending?______________________

3. Are you suing anyone because of your pain or injury?______________________

4. Have you brought suit in the past? ______________________ Outcome?______________________

PAIN INFORMATION

1. What is your main pain problem?______________________
2. Has your pain progressively gotten worse?______________________
3. What caused your current pain?______________________
4. In general, is your pain worse: morning afternoon evening night unknown
5. What do you do to decrease your pain?______________________
6. What do you do that increases your pain?______________________
7. How often do you have rest or a break from your pain?______________________

8. Has your pain interfered with:

Household chores	Spending time with family/friends	Sexual activity
Yard work	Recreational activities	Physical activity
Shopping	Sleeping	Eating

9. Has your pain affected your relationship with your family/friends? YES NO

If so, how?______________________________

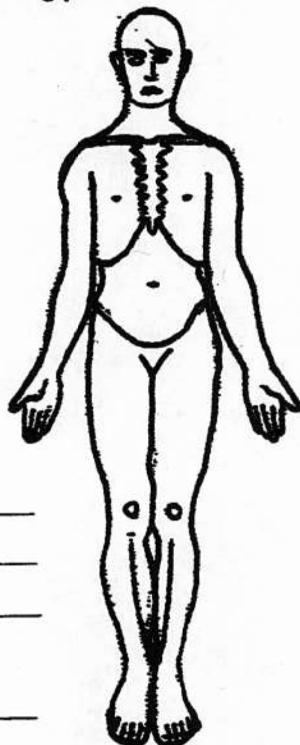
10. What level of treatment are you expecting from the Pain Clinic?______________

11. Please give any additional information that you think we should know:______________

____

PAIN DIAGRAM

Directions: Shade in the areas where you are currently having pain



Pain #1 – Most Severe Pain

Where is it?______________

When did it start?______________

Was there an accident?______________

On a scale of 1 to 10, with 10 being the worst
Pain, when is this at its:
Worst:______________

Best:______________

Now:______________

On average:______________

Describe the pain:______________

Is your pain continuous or intermittent?______________

____

Pain #2 – Accompanied Pain

Where is it?______________

Where did it start?______________

On a scale of 1 to 10, with 10 being the worst
Pain, when is this pain at its:
Worst:______________

Best:______________

Now:______________

On average:______________

Describe the pain:______________

Does your pain stop or is it intermittent? (starts and stops)______________

SOCIAL HISTORY

1. Do you smoke? ________ How many packs per day? ________ How long? __________
2. Do you drink alcoholic beverages? ______________
    a. What type? ________________ How often? ________________________
3. Do you use any recreational drugs? ______________
    a. What type? ________________ How often? ________________________
4. What is your current/most recent occupation? ______________________________
5. What is your current employment status? _________________________________
6. Has your employer been helpful and understanding of your pain issue? _______________
7. Would you return to work if your pain issues were resolved? ____________________
8. Have you tried to return to work? ______________________________________
9. Is your previous job still open to you? ___________________________________
10. When was your last day of work? Month _________ Day _________ Year ___________

FAMILY HISTORY

Please list your family members' medical history. (For example: arthritis, osteoporosis, hemophilia, high blood pressure, high cholesterol, acid reflux, cancer, heart disease, etc.....)

Father: ____

Mother: ____

Paternal Grandfather: ________________________________

Paternal Grandmother: _______________________________

Maternal Grandfather: ________________________________

Maternal Grandmother: _______________________________

Siblings: ____

Is your family supportive of your pain issues? ______________________________

Your marital status: ____________ Children? ____________ Age(s): ____________

Are your living in a house, condo, apartment, nursing home, other? _____________________

COPING INFORMATION

1. Have you experienced physical, emotional, sexual abuse? ____________________
    a. If yes, please explain: ________________________________
2. Have you ever had psychiatric/psychological treatment? ____________________
3. For your pain, please check all the treatments you have tried and when:

Physical Therapy __________ Nerve Block Injections __________ Heat Treatment __________

Exercise ______________ TENS Stimulator ______________ Massage Therapy ________

Acupuncture __________ Traction __________ Other ______________________________

4. Of the above treatments, which helped and for how long? ______________________________
5. Have you ever been in treatment for misuse of alcohol/illegal drugs/prescribed meds? ______________
If yes, where and when? ____
6. Are there things causing stress in your life other than your current pain problem? ______________
If yes, please describe: ____
7. In the past year, has your weight increased or decreased? ____________ How much? _____lbs
8. If your weight decreased, were you dieting? ______________________________

MEDICAL INFORMATION

1. Do you have any allergies? ______________________________________
2. Aside from your pain problem, how is your current health? ______________________
3. Please check all the following health problems that have applied or current apply to you:

High Blood Pressure ____ Diabetes ____ Angina or chest pain ____
Thyroid Problems ____ Heart Attack ____ Kidney problems ____
Bowel Problems ____ Liver Disease ____ Blood/Clotting Issues ____
Seizure/Epilepsy ____ Stroke ____ Cancer ____
Bleeding Issues ____ Arthritis ____ Stomach Issues ____
Osteoporosis ____ Asthma/TB ____ Recent Falls ____
Need for Antibiotics prior to surgery ____ Recent Change in mobility/self-care ____

4. What is your functional status: (circle one) Independent Difficulty w/ balance History of Falls

5. Check any of the following that you currently use:

Glasses ____ Cane ____ Brace ____ Wheelchair ____ Hearing Aid ____
Walker ____ Crutches ____ Dentures ____ Prosthesis ____
Other ____

IMAGING

Please list any imaging you have had done in the past 2 years related to your pain:

DATE	TYPE OF IMAGE	WHERE IT WAS DONE

MEDICATIONS LIST

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING NOW FOR ANY REASON, PRESCRIBED BY A DOCTOR OR NOT.

NAME OF DRUG	DOSAGE (MG)	TIMES TAKEN PER DAY	REASON FOR TAKING

Please list any medications that you have taken in the past for your pain and why you are no longer taking them:

1. ____
2. ____

SURGERIES

Please list all the surgeries you have had:

DATE	HOSPITAL	DOCTOR	TYPE OF SURGERY	DID IT HELP?

PLEASE LIST ANY MEDICAL CONDITIONS, WHEN YOU WERE DIAGNOSED, AND THE TREATING PHYSICIAN:

DATE DIAGNOSED	MEDICAL CONDITION	TREATING PHYSICIAN

PLEASE TELL US IF THERE IS ANYTHING ELSE YOU FEEL WE SHOULD KNOW THAT MAY HELP US TO TREAT YOU

Benjamin Lee, MD
2012 South Tollgate Road
Suite 111
Bel Air, MD
(P) 443-490-4000
(F) 443-484-2831

Privacy Policy Statement

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice if Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:
Office Manager
Address: P.O. Box 997, Bel Air, MD 21014
Phone: 443-490-4000

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. **Treatment.** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests done (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice, including, but not limited to, our doctors and nurses may use or disclose your PHI in order to treat you or to assist others in you treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may disclose your PHI to other health care providers for purposes related to your treatment.
2. **Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
3. **Heath Care Operations.** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
4. **Disclosures Required By Law.** Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and Disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information.

1. **Public Health Risks.** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
    - Maintaining vital records, such as births and deaths,
    - Reporting child abuse or neglect,
    - Preventing or controlling disease, injury or disability,
    - Notifying a person regarding potential exposure to a communicable disease,
    - Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
    - Reporting reactions to drugs or problems with products or devices,
    - Notifying individuals of a product or device they may be using has been recalled,
    - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
    - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
2. **Health oversight activities.** Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, 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.

Benjamin Lee, MD
Pain Management Consultant

Rights and Responsibilities Form

As a patient of Dr. Benjamin Lee, your safety, well being and comfort is of top priority. While a patient with us, it is important to know what your rights and responsibilities are. Please take a moment to review the following list of rights and responsibilities and don't hesitate to ask a member of our administrative staff to clarify any one of these that are unclear to you. We would also be glad to provide our patients who suffer from poor vision with a large text version of this upon request.

YOUR RIGHTS:

-You have the right to be informed of the services Benjamin Lee M.D provides comprehensive pain assessments as well as several treatment modalities with the goal of managing and treating your pain. If requested, a complete list of services will be made available to you or you may visit our website at www.mdpainpro.com.

-You have the right to receive considerate and respectful care regardless of race, gender, nationality, religious preference, age, sexual orientation, or physical and mental disabilities.

-You have the right to have such factors as spirituality, cultural and psychological variables taken into consideration when care is planned.

-You have the right to receive care in an environment free of abuse, neglect, or harassment.

-You have the right to be called by your proper name.

-You have the right to know the names of all people involved in your care.

-You have the right to be informed by your doctor about your diagnosis and possible prognosis.

-You have the right to be informed of the benefits and risks of treatment, and the expected outcome including unanticipated outcomes.

-You have the right of informed consent before your procedure.

-You have the right to have your pain assessed and participate in decisions about managing your pain.

-You have the right of free will and will not be restrained or secluded in any way that is not medically necessary.

-You will receive full consideration of your privacy and confidentiality in examinations, treatment sessions, and care discussions with you healthcare provider.

-You have the right to ask for communication assistance if you have a visual, speech or hearing impairment. Should you have a physical impairment, you have the right to request reasonable accommodations to ensure access to the facility.

-You may ask for a chaperone to be present during your examination.

-You and your family members, with your permission, have the right to participate in discussions regarding your care and you have the right to refuse care. Should you choose to not follow the medical advice of the doctor, neither he, his staff, or Benjamin Lee M.D can be held accountable for the medical consequences.

-You have the right to refuse participation in medical research studies.

-You have the right to be notified of any lapse in malpractice insurance coverage and to seek treatment elsewhere.

-You have the right to receive advanced notice of your discharge from the facility, should the need arise. You can except to receive information directing you to the appropriate health care provider.

-You can expect that all communications and records regarding your healthcare are kept confidential, unless disclosure is allowed by law. This includes but is not limited to information disclosed at your request in a signed release, information provided to your Health Insurance Company for the purpose of reimbursement, and the sharing of information between your healthcare providers.

Revised/Approved 08/2016