MDY PRIMARY CARE MEDICINE, P.L.
MARGARET R YEE, M.D.
PATIENT INFORMATION

DATE:_____

NAME:_____
LAST FIRST MIDDLE

LOCAL ADDRESS:_____

CITY:_____STATE_____ZIP_____

PERMANENT ADDRESS:_____

CITY:_____STATE_____ZIP_____

HOME PHONE (____) _____ ALTERNATE PHONE (____) _____

SS# _____ SEX M OR F BIRTHDATE_____ AGE_____

HEIGHT:_____WEIGHT _____ EMAIL_____

RACE _____ ETHNICITY (Circle One) Hispanic or Non-Hispanic LANGUAGE_____

MARITAL STATUS (Circle One) Single, Married, Divorced, Legally Separated, Widowed

PREFERRED PHARMACY: _____
(NAME AND ADDRESS)

EMERGENCY INFO:

NAME: _____RELATION_____ PHONE_____

PRIMARY INSURANCE INFORMATION:

SUBSCRIBERS NAME (GUARANTOR) _____

SS# _____BIRTHDATE_____ RELATION Self /Spouse /Child /Other

INS COMPANY NAME_____DED $ _____ COPAY $_____

POLICY# _____ GROUP# _____EFF DATE_____

EMPLOYER NAME _____

PATIENT'S STATEMENT:

I hereby allow MDY Primary care Medicine, P.L. to accept assignment of benefits to which I am entitled from my insurance company. I authorize any holder of medical information about me or my dependents to be released to HCFA and its agents. I also authorize my Insurance Company to receive any information needed to determine the benefits payable for related services. I agree that I am responsible for payment of any remaining balance after insurance payments have been made, including collection costs. I also understand that if my account is not paid under the terms of our agreement, I and my immediate family members may be henceforth dismissed from the practice.

Signed_____ Date_____

MDY PRIMARY CARE MEDICINE, P.L.
102 PARK PLACE BLVD
DAVENPORT, FL 33837

Patient Name:_____ Date of Birth:_____

BASIC POLICY Payment for service is due in full at the time service is provided.

FOR PATIENTS WITH INSURANCE We bill most insurance carriers for you if proper paperwork is provided to us. We will also file most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

MEDICARE PATIENTS We will bill Medicare for you. All co-insurance (20%) or deductibles are due and payable at the time service is provided. We will file secondary insurance, for your reimbursement, as a courtesy. If you secondary insurance pays to you it is your responsibility to send the payment to us.

NONCOVERED SERVICES Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

MEDICAL RECORDS FAX I authorize MDY Primary Care Medicine, P.L. to transmit my records electronically. If they are received by another party in error, I absolve MDY Primary Care Medicine, P.A. of any and all liability relating to such submission of said records.

Signature_____ Date_____

CONSENT FOR TREATMENT AND LIFETIME AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I hereby give consent to MDY Primary Care Medicine, P.L. to provide whatever treatment they deem necessary to the patient.

I certify that the information I furnish is true and correct. I am fully aware that it is a felony to falsify any information relating to my medical condition.

I hereby authorize MDY Primary Care Medicine, P.L. to submit a claim to my insurance carrier, or its intermediaries for all covered services rendered by the physician. I also authorize my insurance carrier, or its intermediaries to issue payment directly to the physician. A photocopy of this assignment is considered to be as valid as an original.

I hereby authorize MDY Primary Care Medicine, P.L. to furnish complete information requested by my insurance carrier, or its intermediaries regarding services rendered.

I further agree that I am responsible for payment of any remaining balance after insurance payments have been made, including any collection costs or legal fees incurred to collect these balances.

Signature of Patient:_____ Date:_____

Signature of Guardian _____ Date:_____

HISTORY & PHYSICAL

Formedic

PAGE # CHART #

NAME ..... DATE .....

ADDRESS ..... (M) (F) MARITAL STATUS S M W D SEP DATE OF BIRTH .....

OCCUPATION/ EMPLOYER ..... PHONE (H) ..... (O) .....

INSURANCE .....

FAMILY HISTORY *IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE*

1) EPILEPSY	6) THYROID DISEASE	11) OSTEOPOROSIS	16) LIPID DISORDER
2) MIGRAINE	7) HAYFEVER	12) ARTHRITIS	17) ALCOHOLISM
3) MENTAL ILL.	8) ASTHMA	13) HEART DISEASE	18) HEPATITIS
4) GLAUCOMA	9) ANEMIA	14) STROKE	19) CANCER
5) DIABETES	10) BLEEDS EASILY	15) HYPERTENSION	20)

HOSPITAL ADMISSIONS *not including pregnancies*

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING

ALLERGIES

VACCINE	YEAR OF LAST	TEST / EXAM	YEAR OF LAST
Tetanus / Td		Rectal/Stool	
Influenza (FLU)		Cholesterol	
Pneumonia		Eye	
Hepatitis			
Tuberculosis			

MEDICAL HISTORY *MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.*

MAIN PROBLEMS 1) ..... 2) ..... 3) .....

- ☐ Decreased hearing
- ☐ Ringing in ear
- ☐ Ear infections - *frequent*
- ☐ Dizzy spells ☐ Fainting spells
- ☐ Failing vision ☐ Eye pain
- ☐ Double or blurred vision
- ☐ Nose bleeds - *recurrent*
- ☐ Sinus trouble
- ☐ Sore throats - *frequent*
- ☐ Hoarseness - *prolonged*
- ☐ Hayfever / Allergies
- ☐ Pneumonia / Pleurisy
- ☐ Bronchitis / Chronic cough
- ☐ Asthma / Wheezing
- ☐ Shortness of breath:
  - ☐ on exertion ☐ lying flat
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Heart murmur ☐ Swollen ankles
- ☐ Irregular pulse ☐ Palpitations
- ☐ Leg pain - *when walking*
- ☐ Varicose veins / Phlebitis
- ☐ Cold numb feet

- ☐ Loss of appetite - *recent*
- ☐ Difficulty swallowing
- ☐ Heartburn ☐ Peptic ulcer
- ☐ *Persistent* nausea / Vomiting
- ☐ Abdominal pain- *chronic*
- ☐ Gall bladder trouble
- ☐ Jaundice / Hepatitis
- ☐ Diarrhea ☐ Constipation
- ☐ Diverticulosis ☐ Crohn's / Colitis
- ☐ Bloody or tarry stools
- ☐ Hemorrhoids ☐ Hernia
- Urination - Overactive Bladder
  - ☐ Overnight > than twice
  - ☐ More than 8 times / 24 hrs.
  - ☐ Urgency to urinate ☐ with leakage
- ☐ Decrease in force/flow ☐ Painful
- ☐ Stress incontinence-urine leakage with exercise / movement
- ☐ Blood in urine ☐ Kidney stones
- ☐ Urine infections - *frequent*
- ☐ Sexually transmitted diseases
- ☐ Weight-loss ☐ Gain-*recent*
- ☐ Anemia ☐ Bruise easily
- ☐ Blood transfusions

- ☐ Cancer ☐ Chronic fatigue
- ☐ Diabetes ☐ Thyroid disease
- ☐ Seizures ☐ Stroke
- ☐ Tremor / hands shaking
- ☐ Numbness / tingling sensations
- ☐ Headaches - *frequent*
- ☐ Arthritis / Rheumatism
- ☐ Back pain - *recurrent*
- ☐ Bone fracture / joint injury
- ☐ Osteoporosis
- ☐ Foot pain ☐ Gout
- ☐ Rashes ☐ Hives
- ☐ Psoriasis ☐ Eczema
- ☐ Sleeping or concentration difficulty
- ☐ Depression ☐ Nervousness
- ☐ Agitation ☐ Memory loss
- ☐ Moodiness ☐ Suicidal thoughts
- ☐ Phobias ☐ Mental illness
- ☐ Feelings of worthlessness
- ☐ Rheumatic Fever ☐ Scarlet Fever
- ☐ Chicken Pox ☐ Polio ☐ Mumps
- ☐ Measles ☐ German Measles
- ☐ Tuberculosis ☐ Herpes
- ☐ Aids / HIV

- ☐ Alcohol ..... oz. per week
- ☐ Coffee / Tea ..... cups per day
- ☐ Smoking ..... cig/day ..... #years ..... year quit
- ☐ Excercise
- ☐ Street Drugs
- ☐ Accupuncture / tatoos

Hair loss: ☐ progressive ☐ recent

FEMALES - *Please complete*

Menstrual flow:

☐ Reg. ☐ Irreg. ☐ Pain / Cramps

Days of Flow ..... Length of cycle .....

Date -1st day of last period .....

☐ Pain / Bleeding during or after sex

Number of:

Pregnancies ..... Abortions .....

Miscarriages ..... Live births .....

Birth control method .....

B.C. pill (name) .....

☐ Flushing / Menopause

Date of last PAP test .....

☐ Normal ☐ Abnormal

Date of last Mammogram .....

☐ Normal ☐ Abnormal

SYNOPSIS

2000A FORMEDIC® 120 WORLDS FAIR DR SOMERSET NJ 08873

APPROVED BY FORMEDIC'S PHYSICIAN ADVISORY BOARD PCHPLE®

DECLARATION OF ADVANCE DIRECTIVES

Declaration to Decline Life-Prolonging Procedure (Living Will)

- ☐ I have made such a declaration in writing.
- ☐ I have NOT made such a declaration in writing.

Health Care Surrogate

- ☐ I have designated a Health Care Surrogate in writing.
- ☐ I have NOT designated a Health Care Surrogate in writing

Durable Power of Attorney

- ☐ I have appointed a Durable Power of Attorney for Health Care decisions.
- ☐ I have NOT appointed a Durable Power of Attorney for Health Care decisions.

Copy of Living Will/Proxy/Surrogate/Power of Attorney on chart

☐ YES ☐ NO

I have been provided with information written/verbal regarding the Patient Self Determination Act.

Signature _____ Date _____

Print Name _____

Yearly Reconfirmation

I acknowledge that this information remains accurate

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

MDY Primary Care Medicine, PL
Credit Card Authorization Form

Patient Name: _____ DOB: _____
Guardian's Name (If applicable): _____
Email: _____
Phone Number: _____ Alt #: _____

The purpose of this form is to authorize MDY Primary Care Medicine, PL (MDYPCM) to retain a valid credit card number on file for you, our patient. **All new patients are required to complete this form.**
This form will be kept confidential and only authorized staff will have access to the information.

Your supplied credit card will be charged **ONLY** under the following circumstances:

1.) If you, as the patient receives services within our office that are non-covered, denied, applied to deductible, or for any reason not paid by your insurance carrier, MDYPCM reserves the right to charge the credit card on file for charges that you are responsible for. An email will be sent to the email that you have provided above and you will have 5 business days to respond. If the charge is over $500, you will receive a phone call at the number you provided in addition to the email. If no response to email/phone call after 5 business days, the credit card on file will be charged. A receipt will be mailed at your request.

2.) If you, as the patient, miss a scheduled appointment without 24 hour notice to cancel or reschedule, MDYPCM reserves the right to charge the credit card listed below, $35.00 for our standard no-show fee. This notice serves as your consent to be charged for any and all no-shows. A receipt will be mailed upon your request. (As is customary, MDYPCM will call the phone number on file to remind you of your scheduled appointment; this reminder is usually done 24 hours prior to your scheduled appointment. It is the patients responsibility to ensure that we have a correct, current telephone number on file.)

3.) If you, as the patient, request paper records and do not pick the records up after preparation, MDYPCM reserves the right to charge the credit card on file for the fees involved. (Medical Records Policy will be followed; consent must be signed, pt will be notified of the cost prior to preparation, MDYPCM will release within 5 business days of receipt of request, pt will be notified once ready.)

Other than the conditions mentioned above, under **NO** circumstances will MDYPCM charge your credit card for anything not discussed with you personally. In conjunction with HIPPA regulations, all credit card information will be confidentially kept within your medical chart in our office. Only authorized staff will be able to access this information.

Acknowledged, Agreed, and Accepted:
Having read this form and talked with the physician, and/or staff, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged accordingly for the conditions listed above.

X_____ _____
Patient Signature *Date*
X_____ _____
Staff Signature *Date*

Name as it appears on Credit Card:_____
Billing Address:_____
_____
VISA/MC/DIS/AMEX # _____
Expiration Date: _____ *CVV:* _____

MDY PRIMARY CARE MEDICINE, P.L.
MARGARET R. YEE, M.D.
102 Park Place Blvd
Davenport, FL 33837
Phone (863) 422-0032
Fax (863) 422-3275

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

Records being requested FROM or RELEASED to: _____
(Circle one) (Name of Provider/Facility)

Address: _____

City, State, Zip code: _____

Phone# _____ Fax# _____

PATIENT'S NAME: _____
(Last) (First) (Middle, Maiden)

PATIENT'S SOCIAL SECURITY NUMBER: _____

PATIENT'S DATE OF BIRTH: _____

NOTE: PATIENT OR REPRESENTATIVE MUST INITIAL APPLICABLE AREAS FOR RELEASE:

To release all psychiatric- psychological information _____ (Initials)
Alcohol, Drug, and Chemical information _____ (Initials)
HIV test and info pertaining to these test or to treatment in connection with these test _____ (Initials)

Date records requested: _____ Signature: _____

*** If the patient is 12 to 17 years old, the parent and patient must sign for release of information**

Witness: _____ Date: _____

NOTE TO RECEIVING PARTY: This information is disclosed to you form records whose confidentiality is protected by law. Any redisclosure is strictly prohibited without the written permission of the patient, client, legal representative identified above.

MDY Primary Care Medicine

Family Practice

Agreement to Receive Chronic Care Management Services

Medicare, effective January, 2015 covers Chronic Care Management (CCM) services.

MDY Primary Care Medicine is now able to provide Chronic Care Management (CCM) services, and I have been informed that I would benefit from CCM services, included those provided in between visits. In addition, I have been informed I meet the clinical eligibility to receive CCM services based on my diagnostic conditions.

The CCM services that MDY Primary Care Medicine will provide me under this agreement include the following:

* Access to my care team 24 hours a day 7 days a week, by means such as email, patient portal secure messaging.

* The ability to get successive, routine appointments with my designated primary care provider or member of my care team

* Care management of my chronic conditions, including timely scheduling of all recommended preventive care services, medication reconciliation, and oversight of my medication management.

* Creation of a comprehensive plan of care for all my health issues that is specific to me and congruent with my choices and values.

* Management of my care as I move between and among health care providers and settings, including:

>> Referrals to other health care providers
>> Follow-up after I visit an emergency room
>> Follow-up after I am discharge from the hospital or other facility.
>> Coordination with home-and community-based providers of clinical services.

Patient name:_____

Signature: _____

102 Park Place Blvd | Davenport, FL 33837 | 863-422-0032

My signature below indicates my understanding and agreement to receive CCM services and that I understand;

* MDY Primary Care Medicine is designated by me for purposes of proving CCM to me and for submitting claims for payment to Medicare for the CCM services

* I will receive a copy of my comprehensive plan of care

* MDY Primary Care Medicine is authorized to electronically communicate my medical information with other treating providers as part of the care coordination involved in CCM services

* Medicare will only pay one professional practice for CCM services provided to me during a calendar month.

* CCM services are subject to the usual Medicare deductible and coinsurance applied to my Medicare Part B services.

* I can revoke this agreement at any time (effective at the end of the current month) and can choose to receive these services from another physician or not to receive CCM services at all after the month in which I revoke this agreement.

Date: _____

Designation of Health Care Surrogate

In the event I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I_____(Name) wish to designate, as my surrogate for healthcare decision:

Name:_____

Street Address:_____City:_____State:_____Zip:_____Phone:_____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name:_____

Street Address:_____City:_____State:_____Zip:_____Phone:_____

I fully understand that this designation will permit my designee to make Healthcare decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care, and to authorize my admission to or transfer from a healthcare facility.
Additional instructions (optional):_____

_____

I further affirm that this designation is not being made as a condition of treatment or admission to a healthcare facility.

Patient Signed:_____Date:_____

Witness Name:_____Witness Name:_____

Date:_____Date:_____

Witness Signature 1:_____ ***Witness Signature 2:*** _____

Living Will

Declaration made this____day of_____(20__), I_____, willfully voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set for below, and I do hereby declare that, if at any time I am incapacitated and:
_____(Patient initial) I have a terminal condition, or
_____(Patient initial) I have an end-stage condition, or
_____(Patient initial) I am in a persistent vegetative state,
and if my primary physician and another consultant physician have determined that there is no reasonable medical probability of my recovery from such a condition, I direct. Life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.
I do____, I do not____desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of Life-prolonging procedures, I wish to designate, as my surrogate to carry out the provision of this declaration:

Name:_____

Street Address:_____City:_____State:_____Zip:_____Phone:_____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.
Additional instructions (optional):_____

_____

Patient Signed:_____Date:_____

Witness Signature 1:_____***Witness Signature 2:***_____

Street Address_____ Street Address:_____

City:_____State:_____ City:_____State:_____

Phone:_____Phone:_____

Welcome to MDY Primary Care Medicine!

We are a patient centered medical home where we aim to achieve the best in your medical care using evidence-based medical principles. The following are our policies and procedures for patients as we care for you.

In office venipuncture is offered as a courtesy to our patients. While a majority of our patients do utilize this service, you also have the option of using Quest or Labcorp.

Our staff are trained professionals whose goal is to help make your office encounters meaningful and productive for your medical health. Please call us first for any basic ailments so that we can work you in the same day for an assessment. We strive to accommodate your medical needs so that you do not have to go to the emergency room for standard medical conditions that we can take care of at the office.

It is the goal to see all of our patients with chronic medical problems at least twice per year, sometimes more, depending on the nature of a patient's concurrent conditions. It has been shown that regular visits are the key to keeping patients from illness as well as prevent complications of disease, avoid hospital admissions and achieve overall health.

The patient is asked to request refills at time of appointment. If refills are needed before your next appointment, please request by calling our refill line. We aim to complete refills in a timely manner. **Signature MD** patients may also request by using private email option.

Copays, coinsurance and any past due balances are to be paid at the time of arrival for your appointment. Some services performed or requested may not be covered by the patients' insurance. The patient acknowledges that in such cases, that the patient is financially responsible for these payments.

HIPAA requires that we do not discuss your personal health information with anyone other than the patient. The patient may sign a release of HIPAA information form if they wish to allow communication with others.

In order to provide a safe environment, disruptive behavior is discouraged in any form, such as yelling, screaming, swearing, angry outbursts. This is not effective means of communication and the patient will be asked to leave the office and practice.

We strive to provide the best healthcare outcomes to our patients, but we realize that sometimes our approach may differ from your preferences. Some differences may involve the patient not taking medications, not making lifestyle modifications, not keeping follow up labs and appointments, not following through with referrals or patients demanding referrals that are not medically necessary. My staff and I will explain our approach, concerns and decisions and if you still disagree, then you must decide whether our methods match your desires. Your health plan has a robust network with a variation of physician philosophies for this very reason. If we cannot meet your desired approach, then we want you to find a physician who does. Similarly, in such cases, the practice may have the prerogative to discontinue the patient/physician relationship. Also, if you leave the practice for any reason, we are not required to accept you back as a patient. The next page lists of expectations, for both yourself and our practice. **Lastly, as a patient centered home, we welcome you to our practice where we make your excellent health outcomes our goal. We look forward to a fruitful experience for both patient and our practice.**

Patient Signature:_____

Printed Name: _____

DOB: _____

Date signed: _____

(c. 07/2020)

LET'S PARTNER FOR YOUR BETTER HEALTH!!
MDY Primary Care Medicine, PL

I will work on my Better Health and commit to living a healthy and active lifestyle. **I will:**

√ Call you first when I'm sick

√ See you at least 2 times each year

√ Visit more often when I'm not well

√ Come see you within 3 days after getting out of the hospital

√ Bring my medication list to all appointments

√ Actively participate in your Care Coordination and Jumpstart programs

√ Let you know how to reach me

√ Look to you as my care quarterback

√ Follow your guidance on use of other physicians

√ Follow your guidance on medication and testing

√ Control my blood pressure

√ Control my cholesterol and blood sugar

√ Complete a living will and appoint healthcare surrogates

√ Committed to being a five-star HEDIS patient

√ Work with you to stop smoking (if I do)

√ Actively work on improving my health

√ Adopt a healthy active lifestyle

√ Exercise and/or use Silver Sneakers

√ Embark on my Better Health journey!

Patient Signaure:_____

Printed Name: _____

Date: _____

My Team and I will provide you with a 5-star program that includes:

√ Same-day appointments when you are sick

√ A 24-hour telephone access line

√ Care monitoring while you are in hospital and afterwards

√ A care coordination team

√ A preventative diagnostic program

√ A thoughtful ongoing care program

√ Care for the majority of your illnesses in my office

√ Referrals to other trusted physicians **when medically necessary**

√ The highest quality care in modern medicine

√ Truly caring about and for you

√ Guidance down the path to Better Health

√ A real Better Health partner!

Doctor:_____
Dr. Margaret Yee, MD

(c. 07/2020)