MICHIGAN PLASTIC SURGERY

LEE H. COLONY, M.D., F.A.C.S.

2900 Hannah Blvd., Suite 110
East Lansing, MI 48823
517-333-4960 888-313-9199 517-333-5970 fax
www.miplasticsurgery.com

Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

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

Email: _____ Home Phone: _____ Cell Phone: _____

Birth date: _____ SSN: _____ Age: _____ Sex: M F

Check Appropriate Box: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____ Employer: _____

Spouse Name: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Contact Home Phone: _____ Work Phone: _____ Cell Phone: _____

Parent/Guardian: _____

Primary Care Physician: _____ Last Exam: _____ Phone: _____

Primary Care Physician Address: _____

May your records be used for private internal Quality Assurance Review and/or private internal Peer Review? YES NO

Who may we thank for referring you to our office? _____

Communication Agreement

What numbers may we call to remind you of your appointment, test results, or surgical information? #: _____

May we leave a message requesting a return call? YES NO #: _____

May we fax medical information to you? YES NO Fax #: _____

May we contact you by email? YES NO Email: _____

May we email you new information on procedure, discounts, and promotions from our website www.miplasticsurgery.com? YES NO

Please list by name anyone we may convey information concerning your health and treatment to (spouse, family, friend, parent).

_____ _____

_____ _____

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Parent or Guardian Name (printed): _____

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Patient Health History

Patient Name: _____ Age: _____ Date: _____

Height: _____ Weight: _____ SSN: _____

Medication Allergies / Reactions: _____

Have you had any of the following?

Head/ Neck

1. Dry eye problems/glaucoma/cataract	Yes	No
2. Thyroid problems	Yes	No
3. Recent voice change	Yes	No

Pulmonary/Lung

4. Shortness of breath	Yes	No
5. Tuberculosis (TB)	Yes	No
6. Coughing up blood	Yes	No
7. Asthma	Yes	No
8. Bronchitis	Yes	No
9. Emphysema	Yes	No
10. Pneumonia	Yes	No
11. Sleep Apnea	Yes	No

Heart/Circulation

12. Chest pain/angina/heart attack	Yes	No
13. Irregular heartbeat	Yes	No
14. Pacemaker	Yes	No
15. Heart murmur/Mitral valve prolapse o	Yes	No
16. High blood pressure	Yes	No
17. Stroke or TIA	Yes	No
18. Artery problem	Yes	No
19. Blood clot/blood disorder	Yes	No
20. Excessive bleeding/bruising/scarring	Yes	No
21. Ankle swelling	Yes	No

Abdominal/Gastrointestinal

22. Recent abdominal pain	Yes	No
23. Recent nausea or vomiting	Yes	No
24. Recent constipation or diarrhea	Yes	No
25. Colon polyps	Yes	No
26. Blood in stools	Yes	No
27. Liver or gallbladder problems	Yes	No
28. Jaundice/Hepatitis/Pancreatitis	Yes	No
29. Ulcers, reflux, or hiatal hernia	Yes	No
30. Hernia	Yes	No
31. Recent weight gain or loss	Yes	No

Kidney/Bladder

32. Kidney stones	Yes	No
33. Incontinence/Difficulty urinating	Yes	No
34. Frequent bladder infections	Yes	No
35. Blood in urine	Yes	No

Neurological

70. High Blood Pressure	Yes	No
36. Frequent headaches/Migraines	Yes	No
37. Epilepsy/seizures/convulsions	Yes	No
38. Belle's palsy/Nerve injury	Yes	No

Musculoskeletal

39. Arthritis/Joint pain	Yes	No
40. Back, Neck, or Shoulder pain	Yes	No
41. Leg pain when walking	Yes	No
42. Lacerations, Wounds, Ulcers, or Sores	Yes	No
43. TMJ	Yes	No
44. Metal Implants	Yes	No
45. Broken bones	Yes	No

(list) _____

Female OB/GYN

46. Breast lump, cyst, dimpling, or biopsy	Yes	No
47. Nipple discharge/inversion	Yes	No
48. Most recent mammogram	__/__/__	
49. Last menstrual period	__/__/__	
50. Abnormal vaginal bleeding	Yes	No
51. Vaginal deliveries	Yes	No

(dates) _____

_____

52. C-Sections	Yes	No

(dates) _____

_____

Other

53. Diabetes	Yes	No
54. Low blood sugar	Yes	No
55. Depression or anxiety	Yes	No
56. Emotional/mental condition	Yes	No
57. HIV /AIDS	Yes	No
58. Cancer	Yes	No

(type) _____

_____

59. Other medical conditions not listed	Yes	No

Smoking, Alcohol, Drugs

60. Do you smoke?	Yes	No

(cigarettes, cigars, chewing tobacco, pipe)

years: _____ Amount per day _____

61. When did you quit? _____

62. Are you around second-hand smoke?	Yes	No
63. Do you drink alcoholic beverages?	Yes	No

Amount: _____ Frequency: _____

64. Do you use other drugs?	Yes	No

(cocaine, marijuana, speed, steroids, other)

Amount: _____ Frequency: _____

Family History Relationship

65. Thyroid problems	Yes	No
66. Asthma	Yes	No
67. Diabetes	Yes	No
68. Heart Attack	Yes	No
69. Stroke	Yes	No
70. High Blood Pressure	Yes	No
71. Blood Disorder	Yes	No
72. Cancer	Yes	No

Type: _____

Healing/Anesthesia

73. Have you ever reacted to anesthesia?	Yes	No
74. Are you sensitive to latex?	Yes	No
75. Are you sensitive to tape?	Yes	No
76. Are you sensitive to suture?	Yes	No
77. Do you have motion sickness?	Yes	No
78. Are you a poor healer?	Yes	No
9. Do you form large scars or keloids?	Yes	No

(list) _____

80. Do you get cold sores?	Yes	No

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Patient Health History

Name:_____ SS#_____

Surgery/ Hospitalizations/Deliveries/Plastic Surgery Consultations:

_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

Medications (prescriptions, "over the counter", birth control pills, vitamins, herbs)

Name:	Dosage:	Frequency:	When you started:

Medication Review (Staff Only)

_____
_____
_____
_____
_____
_____

Patient/Guardian Signature:

_____ Date: _____

Photographic Consent

Patient Name:_____ Date: _____

In connection with the plastic surgical services which I am receiving from Dr. Lee Colony, I consent that photographs, videos, or other images may be taken of me or parts of my body, under the following conditions:

- These photographs may be taken only with the consent of Dr. Colony and under such conditions and at such times as may be approved by him.
- The photographs may be taken by Dr Colony, or someone approved by him.
- The photographs shall be used for medical records, and in the judgment of Dr. Colony, for medical, scientific, promotional, or educational purposes. Such photographs and information relating to my case may be published and republished in medical journals or books, or used for any other purpose Dr. Colony may deem proper in the interest of medical education, knowledge, research, or promotion; provided however, that it is specifically understood that I will not be identified by name.

Patient Signature: _____

Parent or Guardian Signature: _____

Witness Signature: _____

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Insurance Information (if applicable)

Primary Insurance: _____

Insured Name: _____

Address: _____

Phone Number: _____ Insured Employer: _____

Group Number: _____ ID Number: _____ Relationship to Insured: _____

Secondary Insurance: _____

Insured Name: _____

Address: _____

Phone Number: _____ Insured Employer: _____

Group Number: _____ ID Number: _____ Relationship to Insured: _____

Motor Vehicle Insurance (if applicable): _____

Insured Name: _____

Address: _____ Date of Injury: _____

Phone Number: _____

Insurance Number: _____ Relationship to Insured: _____

The patient requesting care is responsible for payment. Co-payments and deductibles are due at the time of service.

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or the corporation as indicated on the claim. A copy of my signature is as valid as the original. I certify that all of the demographic, medical, and insurance information is complete and correct.

Signature of Patient/Guardian: _____ Date: _____

Patient/Guardian name (printed): _____

MICHIGAN PLASTIC SURGERY

LEE H. COLONY, M.D., F.A.C.S.

Notice of Privacy Practices

To our patients – 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 health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our Commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:
Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicates with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for you care, such as family member and friends. We are not required to agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Administrator– Dr. Lee H. Colony, 2900 Hannah Boulevard, Suite 110, East Lansing, Michigan 48823 or by telephone 517-333-4960** for further information. A meeting will be schedule with the Administrator to inspect your records after we receive your request.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Administrator – Dr. Lee H. Colony, 2900 Hannah Boulevard, Suite 110, East Lansing, Michigan 48823**. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact Administrator – **Dr. Lee H. Colony, 2900 Hannah Boulevard, Suite 110, East Lansing, Michigan 48823 or by telephone 517-333-4960.**

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Administrator – Dr. Lee H. Colony, 2900 Hannah Boulevard, Suite 110, East Lansing, Michigan 48823 or by telephone 517-333-4960.** All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact **Administrator – Dr. Lee H. Colony, 2900 Hannah Boulevard, Suite 110, East Lansing, Michigan 48823 or by telephone 517-333-4960.**

I hereby acknowledge that I have been presented with a copy of Dr. Lee H. Colony – Michigan Plastic Surgery – Notice of Privacy Practice

Signature: _____ Date: _____

Printed Name: _____

MICHIGAN PLASTIC SURGERY

LEE H. COLONY, M.D., F.A.C.S.

Patient Financial Policy

- In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our practice administrator. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.
- Unless other arrangements have been made in advance by either yourself or your health coverage carrier, full payment for cosmetic procedures is due ten (10) days prior to your procedure. For your convenience we will accept VISA/Discover/Mastercard and American Express.
- Your insurance policy is a contract between you and your insurance company, the doctor is not involved.
- As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance pay the doctor directly. If your insurance company does not pay the practice within a reasonable length of time, we will have to look to you for payment.
- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for whom we have an agreement and will only require you to pay the authorized co-payment at the time of service. We will collect the co-payment when you are here for your appointment.
- If you have insurance coverage with a plan that we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, our charges for your care and treatment are due at the time of the service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be “not covered”, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- It is the patient’s responsibility to contact their insurance carrier and to know if the doctor is in-network or out of net work according to their plan.
- For all services provided in the hospital, we will bill your health plan. Any balance due is your responsibility and is due upon receipt of a statement from our office.
- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.
- In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know you will need to reschedule your appointment.
- I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Signature of Patient/Guardian: _____ Date: _____

Signature of Co-Responsible Party: _____

Please Print the Name of the Patient: _____

Michigan Plastic Surgery
Lee H. Colony, MD, PC

Informed Consent for Telemedicine Services

PATIENT NAME:_____ Date of Birth: _____

LOCATION OF PATIENT: _____ Date of consent:_____

INTRODUCTION:

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical/dental information for the purpose of improving patient care. Providers may include primary care clinicians, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient healthcare records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS:

- Improved access to medical care by enabling a patient to remain at a remote site.
- More efficient healthcare evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS:

As with any healthcare procedure, there are potential risks associated with the use of telemedicine. The risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant (s).
- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to complete treatment may result in adverse drug interactions or allergic reactions or other judgment errors.

Please initial after reading this page:_____

BY SIGNING THIS FORM, I UNDERSTAND THE FOLLOWING:

1. I understand the laws that protect privacy and the confidentiality of healthcare information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

2. I understand I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and my receive copies of this information for a reasonable fee.

4. I understand a variety of alternative methods of healthcare may be available to me, and that I may choose one or more of these at any time. My clinician has explained the alternatives to my satisfaction.

5. I understand telemedicine may involve electronic communication of my personal healthcare information to other healthcare practitioners who may be located in other areas, including out of state.

6. I understand it is my duty to inform my clinician of electronic interactions regarding my care that I may have with other healthcare providers.

7. I understand I may expect the anticipated benefits from the use of telemedicine in my care, but no results can be guaranteed or assured.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my clinician as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my healthcare.

I hereby authorize LEE H. COLONY, MD, PC to use telemedicine in the course of my diagnosis and treatment.

Signature of patient (or person authorized to sign for patient):

_____ Date: _____

If authorized signer, relationship to patient: _____

Witness: _____ Date: _____

I have been offered a copy of this consent form (patient's initials) _____