LIM-KEITH MULTISPECIALTY MEDICAL CLINIC, INC.

6200 Wilshire Blvd., Ste 1510 • Los Angeles, CA 90048
Tel # (323) 964-1440 • Fax# (323) 9641463

REGISTRATION FORM • FORMA REGISTRACION

PLEASE PRINT • *Favor Usar Letra de Molde*

PATIENT INFORMATION • *Informacion del Paciente*

Date • *Fecha:* _____

Patient Name•
Nombre del Paciente _____
Last Name *Appellido* First Name *Nombre* Middle Initial *Inicial*

Date of Birth • *Fecha de nacimiento* _____ **SS#** : _____ -_____ -_____

Marital Status • *Estado Civil:*
- ❒ Single • *Soltero*
- ❒ Married • *Casado (a)*
- ❒ Divorced • Divociado (a)
- ❒ Widowed • Viudo (a)
- ❒ Domestic Partner • Pareja Domestica

Sex • *Sexo* ❒ Male • Hombre ❒ Female• Hembra

Home Address • *Domicilio*
Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone• *Telefono* (_____) _____ **Cell Phone**• *Telefono Cellular (_____)* _____

E-Mail : _____ **Diver License**• *Numero de Licensia* _____

Ethnicity: ❒Hispanic/Latino ❒ Non-Hispanic/ Non-Latino

Race: ❒Asian ❒Black/African/American ❒Native Hawaiian/Other Pacific Islander ❒American Indian or Alaska Indian ❒White/Caucasian ❒Other _____

Occupation _____
Ocupacion

Employer _____
Nombre de la Compania

Address _____
Domicilio de la Compania

Employer Phone _____
Telefono del Empleador

Primary Care Doctor _____
Doctor Principal

Doctor's Phone # _____ **Fax#** _____
Telefono del Doctor

EMERGENCY CONTACT / *INFORMACION DE LA PERSONA EN CASO DE EMERGENCIA*

Name of Contact •*Nombre* _____

Address •*Domicilio* _____

Relationship • *Relacion* _____

Telephone • *Telefono* _____

REFERRED BY:
Referido por

INSURANCE INFORMATION (SUBSCRIBER) / *INFORMACION DE ASEGURANZA*

❒ Self ❒ Dependent Name• *Nombre* _____

Address •*Domicilio* _____

Telephone • *Telefono* _____ E-Mail :_____

Date of Birth • *Fecha de nacimiento* _____ SS#: _____

Diver License• ***Numero de Licensia*** _____

RelationshipTo Patient • _____
Relacion a patiente

PRIMARY INSURANCE

Insurance Company		
Insurance Plan	**Insurance Group**	**Member ID #**

SECONDARY INSURANCE

Insurance company		
Insurance Plan	**Insurance Group**	**Member ID #:**

AUTHORIZATION & ASSIGNMENT OF BENEFITS */AUTHORIZACION Y ASIGNAMIENTO DE BENEFICIOS*

♣AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

_____
Initial • *Inicial*

I authorize Lim-Keith Multispecialty Medical Clinic to provide medical care treatment. I authorize Lim-Keith Multispecialty Medical Clinic to release medical information to my insurance company(s) necessary for the payment of benefits. I authorize my insurance company (s) to pay benefits directly to Lim-Keith Multispecialty Medical Clinic.

Autorizo Lim-Keith Multispecialty Medical Clinic a proveer cuidado y tratamientos medicos. Autorizo Lim-Keith Multispecialty Medical Clinic a dar la informacion medica que es necessaria para el pago de beneficios a me compania de aseguranza. Autorizo el pago beneficios para ser hecho directamente a Lim-Keith Multispecialty Medical Clinic

_____
Initial • *Inicial*

♣ **FINANCIAL RESPONSIBILITY**. I understand that I am financially responsible for the cost of all medical services. However, Lim-Keith Multispecialty Medical Clinic will bill my insurance company as a courtesy to me.

Yo intiendo que soy responsable financiaramente por todos los cargos. Como quiera, Lim-Keith Multispecialty Medical Clinic le cobrara a me compania de aseguranza como una cortesia.

_____
Initial • *Inicial*

♣**LATE FEES**. Invoices sent to me by Lim-Keith Multispecialty Medical Clinic are due 25 days after the date of invoice. I may be charged 1.5% per month late fee on the unpaid balances. Failure to keep my account current may result in my being denied additional services except in emergencies or if I prepay for additional services. I agree to pay collection costs and reasonable attorney's fees incurred in collecting outstanding account balances.

Las facturas enviadas a me por Lim-Keith Multispecialty Medical Clinic tendran que ser pagados entre 25 dias despues de la fecha de la factura. Yo podre ser cobrado el 1.5% porciento por mas de cargos sin pagar del balancia. De cargos sin pagar del balancia resultaran en ser negado sevicios adicionales excepto en emergencies or si pago por adelantado por servicios Nuevo. Yo estoy decuerdo con costos de colecsion y costos de abogado rasonables ah inquuierdo en colectar balancias de pagados.

_____
Initial • *Inicial*

♣ **MISSING AN APPOINTMENT**. I understand that when I make an appointment, my doctor and his staff will block out time in their schedule to see me. I can cancel my appointment or reschedule it up to 24 hours in advance with no penalty. However, if I do not cancel or reschedule my appointment at least 24 hrs in advance and I fail to show up at the appointed time, I agree to pay a #25.00 fee for the Doctor's time and will be personally liable for the payment in accordance with California State and Federal Laws unless my medical plan specifically exempts me from such payment.

Yo intiendo que cuando hago una cita, mi doctor y sus trajabadores reserbaran tiempo en su agenda para mi. Yo puedo cancelar me cita o cambiar me cita antes de 24 horas en avansado sin ser panado. Si yo no cancelo me cita o cambio mi cita antes de 24 horas en avansado y si no liego a me cita, yo pagare una multa de $25.00 por el tiempo del doctor amenos que mi aseguranza provio estos cargos.

Signature • *Firma del Asegurado*: _____ **Date** • *Fecha*: _____

LIM KEITH
MULTISPECIALTY
MEDICAL CLINIC, INC.

6200 Wilshire Boulevard • Suite 1510
Los Angeles, CA 90048

Telephone: (323) 964-1440
Facsimile: (323) 937-5283
www.Lim-Keith.com

Dear Patients:

Lim-Keith has new cancellation policies as follows:

1. All cancellations for follow-up visits and procedures should be made within 24 hours of the scheduled appointment.

2. If you fail to cancel your appointment within 24 hours, you will be charged $50.00. This fee is not reimbursable by your insurance companies therefore you are personally responsible for the fee.

3. Cancellations may be made 24 hours before your scheduled appointment by calling our office (323) 964-1440 during **regular business hours or sending an e-mail at inquiries@lim-keith.com.**

I have read the above and clearly understand the contents.

Attach Patient Label here

_____ _____

Patient Signature Date:

LIM-KEITH MULTISPECIALTY MEDICAL CLINIC, INC.

6200 Wilshire Blvd., Ste 1510 • Los Angeles, CA 90048
Tel # (323) 964-1440 • Fax# (323) 937-5283

MEDICAL RECORDS REQUEST

I, _____ hereby authorize/consent

Physician/Company	**Contact Person:**
Address:	
City:	**Zip Code:**
Tel #:	**Fax #:**

Type of Records: ❒ Physcian Notes ❒ Labs ❒ X-rays ❒ Others
Period: From _____ to _____

To disclose my medical records and /or any other information pertaining to my medical condition which may include mental health, drug use, AIDS/HIV, etc……. to

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This authorization shall become effective and the duration of this consent shall be no longer than is necessary to effectuate the purpose for which it is given and/or until

_____
EXPIRATION DATE

Date:	**Time:**
Patient Name:	**SS#:**
Date of Birth:	**Tel #:**
Address:	
Patient Signature:	
Witness:	**Relationship to Patient:**

HEALTH QUESTIONAIRE

NAME	CHART #	DATE:	
Address:	Tel#:	DOB	Age:

HISTORY OF ILLNESS: HAVE YOU HAD…

CHILDHOOD					
			CANCER	❒ NO	❒ YES
MEASLES	❒ NO	❒ YES	RHEUMATIC HEART DISEASE	❒ NO	❒ YES
MUMPS	❒ NO	❒ YES	TUBERCULOSIS	❒ NO	❒ YES
CHICKENPOX	❒ NO	❒ YES	VENEREAL DISEASE	❒ NO	❒ YES
DIABETES	❒ NO	❒ YES	CONGENITAL ABNORMALITIES	❒ NO	❒ YES
STROKE/CVA	❒ NO	❒ YES	OTHER SERIOUS DISEASES	❒ NO	❒ YES

ADULT

HAVE YOU HAD ANY SERIOUS ILLNESS? ❒ NO ❒ YES

HAVE YOU BEEN HOSPITALIZED UNDER OR UNDER MEDICAL CARE FOT VERY LONG? ❒ **NO** ❒ **YES**

IF YES, FOR WHAT REASON?

HAVE YOU HAD ANY SURGERY? ❒ **NO** ❒ **YES** **IF YES, LIST SURGERY:**

INJURIES

HAVE YOU HAD ANY BROKEN BONES? ❒ **NO** ❒ **YES** **HAVE YOU HAD HEAD CONCUSSIONS OR INJURIES?** ❒ **NO** ❒ **YES**

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? ❒ **NO** ❒ **YES**

FAMILY HISTORY	IF LIVING		IF DECEASED		Has any blood relative ever had:		
	AGE	HEALTH	AGE AT DEATH	CAUSE OF DEATH			
FATHER					CANCER	❒ NO	❒ YES
MOTHER					TUBERCULOSIS	❒ NO	❒ YES
BROTHER/SISTER					HEART TROUBLE	❒ NO	❒ YES
					STROKE	❒ NO	❒ YES
					CONVULSIONS	❒ NO	❒ YES
HUSBAND/WIFE					SUICIDE	❒ NO	❒ YES
SON/DAUGHTER					INSANITY	❒ NO	❒ YES
					BLEEDING TENDENCY	❒ NO	❒ YES
					GOUT OR ATHRITIS	❒ NO	❒ YES

SOCIAL HISTORY

❒ SINGLE	❒ MARRIED	❒ SEPARATED	❒ DIVORCED	❒ WIDOWED

ARE YOU LIVING WITH YOU HUSBAND OR WIFE OR PARTNER?	❒ **NO**	❒ **YES**			
IS YOUR SEX LIFE SATISFACTORY?	❒ **NO**	❒ **YES**			
DO YOU HAVE DEPENDENTS AT HOME?	❒ **NO**	❒ **YES**			
ALCOHOLIC BEVERAGES?	❒ NEVER	❒ RARELY	❒ MODERATELY	❒ DAILY	EVER? ❒ NO ❒ YES
TOBACCO?	❒ CIGARETTES	PACKS A DAY	❒ DON'T SMOKE	❒ EVER SMOKED	❒ NO ❒ YES
ARE YOU EMPLOYED?	❒ FULL TIME	❒ PART TIME	WHAT IS YOUR JOB?		
ARE YOU EXPOSED TO?	❒ FUMES	❒ DUSTS	❒ SOLVENTS		

EDUCATION: **YEARS**

GRADE SCHOOL _____

HIGH SCHOOL _____

COLLEGE _____

POSTGRADUATE _____

HOW MUCH TIME HAVE YOU LOST FROM WORK BECAUSE OF YOUR HEALTH DURING THE PAST:

❒ 6 MONTHS _____

❒ ONE YEAR _____

❒ FIVE YEARS _____

SYSTEMIC REVIEW: DO YOU HAVE ANY OF THE FOLLOWING				NECK:	
RECENT WEIGHT CHANGE	❒ **NO** ❒ **YES**	**DOUBLE VISION**	❒ **NO** ❒ **YES**	**STIFFNESS**	❒ **NO** ❒ **YES**
HAVE YOU BEEN IN GOOD GENERAL HEALTH MOST OF YOUR LIFE	❒ **NO** ❒ **YES**	**HEADACHES**	❒ **NO** ❒ **YES**	**THYROID TROUBLE**	❒ **NO** ❒ **YES**
SKIN		**GLAUCOMA**	❒ **NO** ❒ **YES**	**ENLARGED GLANDS**	❒ **NO** ❒ **YES**
SKIN DISEASE	❒ **NO** ❒ **YES**	**ITCHING EYES OR NOSE**	❒ **NO** ❒ **YES**	**RESPIRATORY**	
JAUNDICE	❒ **NO** ❒ **YES**	**SNEEZING RUNNY NOSE**	❒ **NO** ❒ **YES**	**UPPER RESP INFECTION**	❒ **NO** ❒ **YES**
HIVES/ECZEMA OR RASH	❒ **NO** ❒ **YES**	**NOSEBLEEDS**	❒ **NO** ❒ **YES**	**COLDS (NOW)**	❒ **NO** ❒ **YES**
FREQ INFECTION/BOIL	❒ **NO** ❒ **YES**	**CHRONIC SINUS**	❒ **NO** ❒ **YES**	**SPITTING UP BLOOD**	❒ **NO** ❒ **YES**
ABNORMAL PIGMENTATION	❒ **NO** ❒ **YES**	**EAR DISEASE**	❒ **NO** ❒ **YES**	**FREQUENT COUGH**	❒ **NO** ❒ **YES**
HEAD EYES EAR NOSE THROAT		**IMPAIRED HEARING**	❒ **NO** ❒ **YES**		❒ **NO** ❒ **YES**
EYE DISEASE OR INJURY	❒ **NO** ❒ **YES**	**DIZZINESS/ TRANSIENT**	❒ **NO** ❒ **YES**		❒ **NO** ❒ **YES**
WEAR EYE GLASSES?	❒ **NO** ❒ **YES**	**EPISODES OF UNCONCIOUSNESS**			❒ **NO** ❒ **YES**

LIM-KEITH MULTISPECIALTY MEDICAL CLINIC, INC.

HEALTH QUESTIONAIRE Page 2 of 2

RESPIRATORY continued…			GYNECOLOGICAL continued …..		
ASTHMA OR WHEEZING	NO	YES	NUMBER OF PREGNANCIES?		
DIFFICULTY BREATHING	NO	YES	NUMBER OF MISCARRIAGES?		
ANY TROUBLE WITH LUNGS	NO	YES	DATE OF LAST CANCER SMEAR & RESULTS		
PLEURISY OR PNEUMONIA	NO	YES	FREQUENCY OF PERIODS, EVERY DAYS		
CARDIOVASCULAR			ANY PAIN WITH YOUR PERIOD? ❒ NO ❒ YES		
CHEST PAIN OR ANGINA PECTORIS	NO	YES	NUMBER OF CHILDREN		
SHORTNESS OF BREATH W/WALKING OR LYING DOWN	NO	YES	DATE OF FIRST DAY OR LAST PERIOD		
DIFFICULTY WALKING 2 BLOCKS	NO	YES	**LOCOMOTOR-MUSCULOSKELETAL**		
HEART TROUBLE OR HEART ATTACKS	NO	YES	VARICOSE VEINS	NO	YES
HIGH BLOOD PRESSURE	NO	YES	WEAKNESS OF MUSCLE OR JOINTS	NO	YES
SWELLING HANDS, FEET ANKLES	NO	YES	ANY DIFFICULTY IN WALKING	NO	YES
AWAKENING IN THE NIGHT SMOTHERING	NO	YES	ANY PAIN IN CALVES/BUTTOCKS ON WALKING	NO	YES
HEART MURMUR	NO	YES	**NEURO-PSYCHIATRIC**		
GASTROINTESTINAL			HAVE YOU EVER HAD PSYCHIATRIC CARE	NO	YES
PEPTIC ULCER (STOMACH OR DUODENAL)	NO	YES	HAVE YOU EVER BEEN ADVISED TO SEE A PSYCHIATRIST	NO	YES
VOMITING BLOOD OR FOOD	NO	YES	DO YOU EVER HAD OR HAVE HAD FAINTING SPELLS	NO	YES
GALLBLADER DISEASE	NO	YES	CONVULSIONS	NO	YES
LIVER TROUBLE	NO	YES	PARALYSIS	NO	YES
HEPATITIS	NO	YES	**HEMATOLOGIC**		
PAINFUL BOWEL MOVEMENTS	NO	YES	ARE YOU SLOW TO HEAL AFTER CUTS?	NO	YES
BLACK STOOLS	NO	YES	BLOOD DISEASE	NO	YES
HEMORRHOIDS OR PILES	NO	YES	ANEMIA	NO	YES
RECENT CHANGE IN BOWEL HABITS	NO	YES	PHLEBITIS	NO	YES
FREQUENT DIARRHEA	NO	YES	DIFFICULTY WITH BLEEDING EXCESSIVELY AFTER TOOTH EXTRACTION OR SURGERY	NO	YES
HEARTBURN OR INDIGESTION	NO	YES			
CRAMPING OR PAIN IN THE ABDOMEN	NO	YES	HAVE YOU HAD Abnormal BRUISING OR BLEEDING?	NO	YES
DOES FOOD STICK IN THE THROAT	NO	YES	**ALLERGIC**		
ANAL CYTOLOGY (?)	NO	YES	ANY ALLERGIES INCLUDING MEDICATION	NO	YES
GENITOURINARY					
LOSS OF URINE	NO	YES	**ENDOCRINE**		
FREQUENT URINATION	NO	YES	THYROID DISEASE	NO	YES
NIGHTTIME URINATION	NO	YES	HORMONE THERAPY	NO	YES
BLOOD IN URINE	NO	YES	ANY CHANGE IN HAT OR GLOVE SIZE	NO	YES
KIDNEY TROUBLE	NO	YES	ANY CHANGE IN HAIR GROWTH	NO	YES
KIDNEY STONES	NO	YES	BECOME COLDER THAN BEFORE OR SKIN BECOME DRIER	NO	YES
BRIGHTS DISEASE	NO	YES			
GYNECOLOGICAL					
AGE PERIOD STARTED					
HOW LONG DO PERIODS LAST					
HEIGHT _____ WEIGHT: _____					

ALLERGIES & SENSITIVITIES

1. IS THERE A HISTORY OF SKIN REACTION OR SICKNESS FOLLOWING ADMINISTRATION OF:

				NAME OF DRUG OR FOOD
PENICILLIN OR OTHER ANTIBIOTICS	NO	YES	DON'T KNOW	
MORPHINE CODEINE DEMEROL OR OTHER NARCOTIC	NO	YES	DON'T KNOW	
NOVOCAINE OR OTHER ANESTHETIC	NO	YES	DON'T KNOW	
ASPIRIN EMPIRIN OR OTHER PAIN REMEDIES	NO	YES	DON'T KNOW	
SULFA DRUGS	NO	YES	DON'T KNOW	
TETANUS ATITOXIN OR OTHER SERUMS	NO	YES	DON'T KNOW	
ADHESIVE TAPE	NO	YES	DON'T KNOW	
IODINE OR MERTHIOLATE	NO	YES	DON'T KNOW	
ANY OTHER DRUG OR MEDICATION	NO	YES	DON'T KNOW	
ANY SUCH FOODS AS EGGS	NO	YES	DON'T KNOW	
MILK OR CHOCOLATE	NO	YES	DON'T KNOW	

2. DRUGS RECETLY TAKEN WITHIN THE LAST 6 MONTHS CIRCLE ONE

				HAS THE PATIENT RECIVED TREATMENT FOR:			
CORTISONE	NO	YES	DON'T KNOW	ASPIRIN	NO	YES	DON'T KNOW
ACTH	NO	YES	DON'T KNOW	ASTHMA	NO	YES	DON'T KNOW
TRANQUILIZERS	NO	YES	DON'T KNOW	RHEUMATISM OR RHEUMATIC FEVER	NO	YES	DON'T KNOW
BLOOD PRESSURE MEDICINE	NO	YES	DON'T KNOW				

DOCTOR	DATE	SIGNATURE OF PATIENT

LIM-KEITH MULTISPECIALTY MEDICAL CLINIC, INC.

Advance Health Care Directive Form Instructions

You have the right to give instructions about your own health care.

You also have the right to name someone else to make health care decisions for you.

The Advance Health Care Directive form lets you do one or both of these things. It also lets you write down your wishes about donation of organs and the selection of your primary physician. If you use the form, you may complete or change any part of it or all of it. You are free to use a different form.

INSTRUCTIONS

Part 1: Power of Attorney

Part 1 lets you:

- **name** another person as **agent** to make health care decisions for you if you are unable to make your own decisions. You can also have your agent make decisions for you right away, even if you are still able to make your own decisions.
- **also name** an **alternate agent** to act for you if your first choice is not willing, able or reasonably available to make decisions for you.

Your **agent** may not be:

- an operator or employee of a community care facility or a residential care facility where you are receiving care.
- your supervising health care provider (the doctor managing your care)
- an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Your **agent** may make all health care decisions for you, unless you limit the authority of your agent. You do not need to limit the authority of your agent.

If you want to limit the authority of your agent the form includes a place where you can limit the authority of your agent.

If you choose not to limit the authority of your agent, your agent will have the right to:

- Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
- Choose or discharge health care providers (i.e. choose a doctor for you) and institutions.
- Agree or disagree to diagnostic tests, surgical procedures, and medication plans.
- Agree or disagree with providing, withholding, or withdrawal of artificial feeding and fluids and all other forms of health care, including cardiopulmonary resuscitation (CPR).
- After your death make anatomical gifts (donate organs/tissues), authorize an autopsy, and make decisions about what will be done with your body.

Part 2: Instructions for Health Care

You can give specific instructions about any aspect of your health care, whether or not you appoint an agent.

There are choices provided on the form to help you write down your wishes regarding providing, withholding or withdrawal of treatment to keep you alive.

You can also add to the choices you have made or write out any additional wishes.

You do not need to fill out part 2 of this form if you want to allow your agent to make any decisions about your health care that he/she believes best for you without adding your specific instructions.

Part 3: Donation of Organs

You can write down your wishes about donating your bodily organs and tissues following your death.

Part 4: Primary Physician

You can select a physician to have primary or main responsibility for your health care.

Part 5: Signature and Witnesses

After completing the form, **sign and date it** in the section provided.

The form must be signed **by two qualified witnesses** (see the statements of the witnesses included in the form) **or** acknowledged before a notary public. **A notary is not required if the form is signed by two witnesses. The wittnesses must sign the form on the same date it is signed by the person making the Advance Directive.**

See part 6 of the form if you are a patient in a skilled nursing facility.

Part 6: Special Witness Requirement

A Patient Advocate or Ombudsman must witness the form ***if you are a patient in a skilled nursing facility*** (a health care facility that provides skilled nursing care and supportive care to patients). See Part 6 of the form.

You have the right to change or revoke your Advance Health Care Directive at any time

If you have questions about completing the Advance Directive in the hospital, please ask to speak to a Chaplain or Social Worker.

We ask that you
complete this form in English
so your caregivers can understand your directions.

Advance Health Care Directive

Name_____

Date_____

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form also lets you write down your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or change all or any part of it. You are free to use a different form.

You have the right to change or revoke this advance health care directive at any time.

Part 1 — Power of Attorney for Health Care

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

Name of individual you choose as agent:_____

Relationship_____

Address: _____

_____

Telephone numbers: (Indicate home, work, cell) _____

ALTERNATE AGENT (Optional): If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Name of individual you choose as alternate agent:_____

Relationship_____

Address: _____

_____

Telephone numbers: (Indicate home, work, cell) _____

SECOND ALTERNATE AGENT (optional): If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Name of individual you choose as second alternate agent: _____

Address: _____

_____

Telephone numbers: (Indicate home, work, cell) _____

(1.2) AGENT'S AUTHORITY: My agent is authorized to 1) make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, 2) to choose a particular physician or health care facility, and 3) to receive or consent to the release of medical information and records, except as I state here:

_____

_____

(Add additional sheets if needed.)

(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I initial the following line.

If I initial this line, my agent's authority to make health care decisions for me takes effect immediately. ____

(1.4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) AGENT'S POST DEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

_____

_____

(Add additional sheets if needed.)

(1.6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named. _____ (initial here)

Part 2 — Instructions for Health Care

If you fill out this part of the form, you may strike out any wording you do not want.

(2.1) END-OF-LIFE DECISIONS: I direct my health care providers and others involved in my care to provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

☐ a) Choice Not To Prolong
I do not want my life to be prolonged if the likely risks and burdens of treatment would outweigh the expected benefits, or if I become unconscious and, to a realistic degree of medical certainty, I will not regain consciousness, or if I have an incurable and irreversible condition that will result in my death in a relatively short time.

Or

☐ b) Choice To Prolong
I want my life to be prolonged as long as possible within the limits of generally accepted medical treatment standards.

(2.2) OTHER WISHES: If you have different or more specific instructions other than those marked above, such as: what you consider a reasonable quality of life, treatments you would consider burdensome or unacceptable, write them here.

_____

_____

_____

_____

_____

Add additional sheets if needed.)

Part 3 — Donation of Organs at Death (Optional)

(3.1) Upon my death (mark applicable box):

☐ I give any needed organs, tissues, or parts

☐ I give the following organs, tissues or parts only:_____

☐ I do not wish to donate organs, tissues or parts.

My gift is for the following purposes (strike out any of the following you do not want):

Transplant Therapy Research Education

Part 4 — Primary Physician (Optional)

(4.1) I designate the following physician as my primary physician:

Name of Physician:_____

Address: _____

_____

Telephone: _____

Part 5 — Signature

(5.1) EFFECT OF A COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURE: Sign name: _____ Date: _____

(5.3) STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this advance directive in my presence (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly nor an employee of an operator of a residential care facility for the elderly.

FIRST WITNESS

Print Name: _____

Address: _____

Signature of Witness: _____ Date: _____

SECOND WITNESS

Print Name: _____

Address: _____

Signature of Witness: _____ Date: _____

(5.4) ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate on his or her death under a will now existing or by operation of law.

Signature of Witness: _____

Signature of Witness: _____

Part 6 — Special Witness Requirement if in a Skilled Nursing Facility

(6.1) The patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OF OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by section 4675 of the Probate Code:

Print Name:_____ Signature: _____

Address: _____ Date: _____

Certificate of Acknowledgement of Notary Public (Not required if signed by two witnesses)

State of California, County of _____ On this _____ day of _____ , _____ , before me, the undersigned, a Notary Public in and for said State, personally appeared _____ , personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument, and acknowledged

to me that he/she executed it.

WITNESS my hand an official seal. Seal

Signature_____

LIM-KEITH MULTISPECIALTY MEDICAL CLINIC, INC.

6200 Wilshire Blvd., Ste 1510 • Los Angeles, CA 90048
Tel # (323) 964-1440 • Fax# (323) 937-5283

ASSIGNMENT OF BENEFITS – FINANCIAL AGREEMENT
RELEASE OF INFORMATION AUTHORIZATION

I understand that I am financially responsible for all charges whether or not they are covered by insurance**.** In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees.

I authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

I hereby give authorization for payment of insurance benefits be made directly to Lim-Keith Multispecialty Medical Clinic, Inc. and any assisting physicians, for services rendered.

Further, if my current policy prohibits direct payment to the doctor, I hereby also instruct and direct my insurance company to make the check out to me and mail it as follows:

LIM-KEITH MULTISPECIALTY MEDICAL CLINIC, INC.
6200 Wilshire Blvd., Ste 1510 • Los Angeles, CA 90048

MEDICARE AND MEDICAL PATIENTS ONLY

I request that payment of authorized Medicare Benefits be made on my behalf to Lim-Keith Multispecialty Medical Clinic, Inc. and any assisting physicians, for any services furnished by said Clinic.

I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I further agree that a photocopy of this agreement shall be as valid as the original

Patient Name: (attach Label)

HIC #:

Signature: _____/_____
PATIENT / LEGAL GUARDIAN (RELATIONSHIP)

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AUTHORIZATION AND CONSENT TO PHOTOGRAPH

The undersigned hereby authorizes Lim-Keith Multispecialty Medical Clinic, Inc. and my physician (s) to photograph or permit other persons to photograph:

Name of Patient: **(attach label)**

While under the care of Lim-Keith Multispecialty Medical Clinic, Inc. The undersigned agrees that Lim-Keith Multispecialty Medical Clinic, Inc, and my physician (s) may use the print prepared from such photograph for the purpose of being placed in my chart only. Such photograph is to be used for identification purposes only and shall not be removed from my chart or used for any other purpose whatsoever without my express permission. The term **"photograph**" shall mean still photograph in any format.

Date: _____ **Time:** _____ ❒ **AM** ❒ **PM**

Signature:

_____

PATIENT / PARENT/GUARDIAN/CONSERVATOR

If signed by other than Patient; Indicate Relationship:

_____

Witness: _____

NAME:	DATE:	CHART#

IN ORDER TO ASSIST THE DOCTOR IN YOUR TREATMENT, PLEASE CHECK ALL SIGNS, SYMPTOMS OR COMPLAINTS THAT ARE APPLICABLE IN TODAY'S VISIT

	GENERAL		CARDIOPULMONARY (HEART / LUNGS)		NEUROLOGIC
☐	Fatigue	☐	Persistent Cough	☐	Headaches
☐	Weight Loss	☐	Shortness Of Breath	☐	Weakness
☐	Fever	❒	At Rest	☐	Seizures
☐	Feeling Of Wellness	❒	On Exertion	☐	Loss Of Memory
☐	Night Sweats	☐	Chest Tightness	☐	Loss Of Concentration
☐	**LYMPH NODES**	☐	Wheezing	☐	Sadness
☐	SWELLING OF GLANDS or	☐	Sputum Production	☐	Mood Swings
☐	NODES IN NECK	☐	Sighing	☐	Numbness
	❒ In the front	☐	**HEMATOLOGIC**	☐	Tingling
	❒ In the back	☐	Easy Bruising	☐	**MUSKULOSKELETAL**
☐	Swelling of Nodes or Glands	☐	Bleeding Anywhere	☐	Loss Of Muscle Tissue
	❒ Under your arms	☐	**GASTROINTESTINAL**	☐	Muscle Spasm
	❒ Behind the ears		(STOMACH / BOWEL)	☐	Weakness Of Specific Muscle
	❒ In your groin	☐	Diarrhea	☐	Pain In Hand
☐	**DERMATOLOGIC**	☐	Anorexia	☐	Pain In Feet
☐	Skin Discoloration	☐	Nausea	☐	Pain In Face
☐	Rash	☐	Vomiting	☐	
☐	Scaling	☐	Loss Of Appetite	☐	
☐	Hair Loss	☐	Constipation	☐	
☐	Eruptions	☐	Black, Tarry Stool	☐	
☐	Easy Bruising	☐	**GENITOURINARY**	☐	**ANORECTAL**
☐	Larg Bruising		(Genital area/urinary tract)		(Buttocks Area)
☐	**ORAL**	☐	Rashes	☐	Anal/Rectal Pain
☐	Discoloration of mouth	☐	Lesions	☐	Swelling Pain
☐	Discoloration of gums	☐	Ulcers	☐	Bleeding
☐	Ulcers	☐	Chancres	☐	
☐	Painful swallowing	☐	Dysuria	☐	
☐	Sore Throat	☐	Discharge	☐	
☐	**VISUAL**	☐	Abnormal PAP Smear	☐	
☐	Visual Field Defects	☐	**OTHERS**	☐	**OTHERS**
☐	Loss Peripheral Vision (Side)	☐		☐	
☐	Visual Field Cuts	☐		☐	
☐	(Pie Wedges of Visual Loss)	☐		☐	
☐	Retinal Hemorrhage	☐		☐	
☐	Exudates	☐		☐	

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GIVE TO PATIENT

INFORMATION REGARDING REQUEST FOR MEDICAL RECORDS

Section 123110 of the California Health and Safety Code specifically provides that a Physician may charge a fee to defray the cost of copying not to exceed 25 cents per page or 50 cents per page for records that are copied from microfilm and with reasonable clerical cost.

As a professional courtesy, Lim-Keith will provide the patient or transfer medical records to another provider without charging a fee only for the current six (6) month records. Medical records transfer to an insurance company or an attorney will be assessed a clerical fee of $25.00 plus 25 cents per page. Medical records for a period of more than six (6) months, requested by the patient, will also be charged the clerical and per page fee.

The identity and signature of the patient requesting the records will be verified prior to copying.

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Name:	**Date:**	**Chart #:**

TO ASSIST US IN YOUR EXAM, PLEASE WRITE THE MEDICATIONS YOU ARE CURRENTLY TAKING

MEDICATION	DOSE	FREQUENCY

Pharmacy Name:	**Pharmacy Telephone:**
	Fax #: