Access Community
Health Center

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
(Last Name, First Name, Middle Name)

Sex: M☐ F☐ **Social Security #:** _____ Marital Status: Married☐ Single☐ Widowed☐ Divorced☐

Address: _____ APT#: _____City: _____State: _____ Zip: _____

Primary Phone #: _____ ☐Cell Phone ☐Home Phone ☐ Work Phone
☐ DO ☐DO NOT Leave Detailed Message

Secondary Phone #: _____ ☐ Cell Phone ☐ Home Phone ☐ Work Phone
☐ DO ☐ DO NOT Leave Detailed Message

Email: _____ ☐**DO** enroll ☐**DO NOT** enroll

Through ***Kareo Patient Portal*** users can view or request appointments, send messages to the doctor or front office staff, request medication refills, lab results, or radiology results, etc.

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ African American ☐Hispanic/Latino
☐ Native Hawaiian/ Pacific Islander ☐ White ☐ Unknown ☐ Other

EMERGENCY CONTACT INFORMATION

Responsible Party: _____ Relationship: _____
Phone Number: _____
Emergency Contact: _____ Relationship: _____
Phone number: _____

☐ I am my own responsible party.
☐ I decline to have an emergency contact listed at this time.

INSURANCE INFORMATION

Primary Insurance Company: _____ HMO_____ PPO _____ POS _____

Policy ID #_____ Group #_____

ADVANCE DIRECTIVE

An Advance Directive is a process of writing your wishes about what type of care you would want or do not want, in case you get hurt, sick, or become unable to make medical decisions for yourself. This typically involves completing a form and selecting an adult relative, spouse, partner, or friend who can make decisions for you when you the time comes. The person you select to represent you is known as your "agent". For this plan to become effective you must sign your name and write the date on the form. For more information, please ask the front desk. For more information, please go to www.caringinfo.org ->download your states Advance Directive / NHPCO -> scroll down and chose California.

_____ _____ _____
Signature of Patient (Or Parent/Legal Guardian) | Print name | Date

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ASSIGNMENT OF BENEFITS

I/We do hereby consent to and authorize the performance of all treatment, surgery, and medical services by the staff of Access Community Health Center which they may deem advisable. I hereby certify that to the best of my knowledge, all statements contained hereon are true. I also hereby authorize Access Community Health Center to release information requested by the insurance company and/or its representative. I hereby agree to assign all benefits payable by my insurance company to my provider, Access Community Health Center.

_____I fully understand the agreement and consent will continue until cancelled by me in writing.

_____I authorize Access Community Health Center to render necessary medical or surgical treatment to the above named minor of whom I am the parent or legal guardian.

FINANCIAL AGREEMENT

I understand that I am directly responsible for all charges incurred for medical service for myself and my dependents regardless of insurance coverage, excluding only authorized covered services provided under a valid prepaid HMO contract. I hereby agree to pay the interest rate of 10% per annum for all outstanding charges incurred for medical services for myself and my dependents. I furthermore agree to pay legal expenses including court cost and reasonable attorney's fee, collection agency expense, and all expenses incurred to collect an amount I may owe as allowed by the state and federal laws. Because my provider is billing my insurance as a courtesy and for this reason I may incur debt to my provider, I hereby authorize the verification of my employment, in the event, I do incur debt to my provider.

_____	_____	_____
Signature of Patient/Guarantor	Print Name	Date
_____	_____	_____
Signature of Guarantor (If patient is a minor)	Print Name	Date

Cancellation Fee Schedule

Missed appointments without prior or late notification translate to missed revenue for any provider. Frequently missed appointments results in significant financial loss to any provider. Access Community Health Center reserves the right to terminate medical services and/or the right to charge a fee for any scheduled visits to patients who:

1. Cancelled with less than 24-hour notice.
2. Missed the appointment without calling to cancel (no show)
3. Patients who are 15 minutes late or more will have to reschedule and will be considered a no show.

Other Office Fees

Access Community Health Center requires payment for the completion of forms or letters. A charge of $25 **per single page form** is due at the time of pick up. If your form is **more than one** page the charge will be $50.

- ❖ By signing below, I attest that I have read and understood the agreement and policy above.

Patient/Guarantor Signature: _____ Date: _____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby give my consent for Access Community Health Center to use and disclose protected health information about me to carry out treatment, payment, and health care operations. The Notice of Privacy Practices provided by Access Community Health Center describes such uses and disclosures more completely. I have the right to review the Notice of Privacy Practices prior to signing this consent. Access Community Health Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Ruth Fletcher/ Alvin Chang MD
Access Community Health Center

14642 Newport Ave Suite 101
Tustin CA, 92780

520 N. Main St. Suite 120
Santa Ana CA, 92701

24953 Paseo De Valencia Suite 7-C
Laguna Hills, CA 92653

With this consent Access Community Health Center may call my home or other alternative location and leave a message or voice mail or in person in reference to any items that assist the practice in carrying out my treatment, payment of health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Access Community Health Center may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment, or health care operations, such as appointment reminder cards and patient statements. I have the right to request that Access Community Health Center restrict how it uses or discloses my protected health information to carry out treatment, payment, or health care operations. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Access Community Health Center to use and disclose my protected health information to carry out treatment, payment, or health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Access Community Health Center may decline to provide treatment to me.

_____ _____
Signature of Patient (or Parent/Legal Guardian) Date

_____ _____
Print Patient's Name Parent/Legal Guardian Name (if applicable)

ACKNOWLEDGEMENT OF RECEIPT OF ACCESS COMMUNITY HEALTH CENTER NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have been provided a copy of the Notice of Privacy Practices. This notice explains how my personal information can be used and disclosed by this medical office.

Printed Patient's Name: _____

Signature: _____ **Date:** _____
Signature of Patient (or Parent/Legal Guardian)

Access Community
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AUTHORIZATION TO SHARE PROTECTED HEALTHCARE INFORMATION

Your authorization will allow us to share your medical information with those identified family members, Caregivers or others that are involved in your care.

1. Extent of Authorization:

a. ☐ I authorize the release of my complete health record.

b. ☐ I **do not** wish to release my health records.

c. ☐ I authorize the release of my records except for the following information:

☐ Mental health records ☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/Drug abuse treatment Other (please specify) _____

2. Authorization: I authorize **Access Community Health Center** to use and disclose the protected information described below to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

3. Effective Period: This authorization for release of information covers the period of healthcare from:

☐ All past, present, and future periods or ☐ From dates: _____to_____

4. This medical information may be used for
1) Medical Treatment **2)** Billing purposes or **3)** Other purposes I Choose by those who have permission.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that if I cancel this authorization, it will not be effective **1)** for those individuals who have already received information based on the previous authorization, **2)** if my authorization was obtained for the purpose of obtaining insurance coverage, the insurer has a legal right to information related to claims.

6. I understand that once the information is disclosed to the authorized person the medical group can no longer protect the information by federal or state law.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be affected by this authorization.

Print Patient's Name: _____

Signature: _____ **Date:** _____
Signature of Patient (or Parent/Legal Guardian)

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MEDICAL HISTORY FORM

Pharmacy	Pharmacy name	Phone number	Fax number
Local Pharmacy			
Mail order			

MEDICATION

Please list all prescription medications, over the counter medications, birth control, vitamins you are currently taking. (Name, daily dosage, start date) If more space is needed, please ask the front desk.

_____
_____
_____
_____

☐ I do not take any medications.

PLEASE LIST ALL KNOWN ALLERGIES AND REACTIONS

_____
_____
_____

☐ No known allergies

CHRONIC PROBLEMS

Please list all chronic problems and year of onset (Examples: Diabetes, Hypertension, Heart Disease, etc.)

_____
_____
_____

PLEASE LIST PRIOR SURGERIES AND HOSPITALIZATIONS/YEAR OF ONSET

_____
_____
_____

FAMILY/SOCIAL HISTORY ☐ Unknown family history ☐ Adopted

Please indicate if any family member has had any of the following conditions. Please add age of onset.

Family member	Good health	Heart disease	Hypertension	Stroke	Cancer type	Other Illness
Father						
Mother						
Paternal Grandmother						
Paternal Grandfather						
Maternal Grandmother						
Maternal Grandfather						
Sister						
Brother						
Other						

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MEDICAL HISTORY FORM (CONT'D)

1. Briefly describe your occupation:

   _____

2. Briefly describe you living situation: (Who lives with you, house apartment, pets)

   _____

3. Tabaco use: ☐ Current ☐ Former Never * Are you ready to quit? _____

   Cigarettes per day: _____ Years used: _____ Quit: _____

4. Alcohol use: ☐ Yes ☐ No ☐ Former How often? _____ Amount: _____

5. Exercise/ Activity: ☐ Yes ☐ No How often: _____

<u>Confidential information:</u>

6. Recreational drugs: ☐ Yes ☐ No ☐ Former

   Drug type: _____How often: _____

7. Do you have any concerns for your safety? _____

HEALTH MAINTENANCE

Please indicate when was the last exam, immunization received?

Exam	Year	Vaccine	Year
Mammogram		HPV (Gardasil)	
Pap Smear		Tdap (Tetanus)	
Colonoscopy		Influenza	
Bone Density		Shingles	
Eye Exam		Pneumovax	
Dental Exam		PPD Screening	
Bloodwork		PPD	Result:
Physical Exam		Other:	

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Adult Tuberculosis Risk Assessment

Date Completed: _____

Patients Name: _____ Date of Birth: _____	*** Office Use Only*** Providers Name: _____

LTBI testing is recommended if any of the boxes below are checked.

☐ **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month

- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
- If resources require prioritization within this group, prioritize patients with at least one medical risk for progression (see the California Adult Tuberculosis Risk Assessment User Guide for this list).
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for non-U.S.-born persons ≥2 years old

☐ **Immunosuppression,** current or planned

HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication

☐ **Close contact** to someone with infectious TB disease during lifetime

Treat for LTBI if LTBI test result is positive and active TB disease is ruled out.

☐ **None**; no TB testing is indicated at this time.