PATIENT REGISTRATION FORM

Patient Information		
Last Name:	**First Name:**	**Middle Name**:
Date of Birth:	**Social Security Number:**	
If Minor, Guardian Name and Relation to Patient:		
Gender Identity: ☐ Choose not to disclose ☐ Male ☐ Female ☐ Transgender ○ Male-Female ○ Female-Male ☐ Non-Binary Preferred Pronouns: ☐ she, her, hers ☐ he, him, his ☐ they, them, theirs ☐ not listed **Preferred name** :_____ (*For billing purposes the name listed on your chart will be shown as your legal name, but office staff will make notation in your chart and make every attempt to address you by your preferred name)*		
Address: ☐ Homeless	**City:**	**State:** / **Zip Code:**
Mailing Address *if different*:		
Primary Phone: ☐ Home ☐ Cell ( )	**Alternate Phone:** ☐ Home ☐ Cell ( )	
E-Mail Address:		
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Seperated ☐ Widowed ☐ Other: _____		
Primary Language: **Interpreter Needed:** ☐ Yes ☐ No	**Religion:**	
Ethnicity:	**Race:** ☐ White ☐ Hispanic ☐ Native/American Indian ☐ Black-African American ☐ Asian-Pacific Islander ☐ Other:_____	
Emergency Contact		
Last Name, First Name:	**Relationship:**	**Phone Number:**
Employment		
Employment Status ☐ Student: ☐ Full-time ☐ Part-time ☐ Retired ☐ Self-employed ☐ Employed: ☐ Full-time ☐ Part-time ☐ Unemployed		
Employer Name:	**Occupation:**	
Employer Address:	**Employer Phone:**	
Pharmacy Information		
Name:	**Address:**	**Phone Number:**

OFFICE FINANCIAL POLICIES

Primary Insurance (Policy Holder) Information	☐ **Self**
Insurance Name:	Subscriber Name:
Subscribors Date of Birth:	Relation to patient:
Subscriber ID:	Group Number:
Secondary Insurance (Policy Holder) Information	☐ **Self**
Insurance Name:	Subscriber Name:
Subscribors Date of Birth:	Relation to patient:
Subscriber ID:	Group Number:
Tertiary, Prescription or Other Insurance Information (For prescription please include PCN and BIN)	
Responsible Party (Guarantor)	☐ **Self**
Last Name, First Name:	Relationship:
Date of Birth:	Social Security Number:
Phone: ☐ Home ☐ Cell ( )	

The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company. I assign benefits otherwise payable to me to Atiga Family Practice (*Rolando A Atiga, MD, A Professional Corp.*). Financing and financial assistance is available if needed, please speak with our office manager if you need to make arrangements for payment.

We need a copy of both the front and back of your all insurance cards on file in your chart, including your prescription coverage cards. If all the necessary information required to bill your insurance is not received, then your account will be managed the same as cash pay.

For those who are paying cash, unless arrangements have been made prior, payment must be paid in full at the time of service. Provider office visit for cash pay is $100 and a nurse visit is $25. For immunizations, procedures or other items please confirm charges with office staff prior to receiving services.

For Laser treatment services please ask a member of staff for pricing information and monthly specials.

All HMO patients must be assigned to either Dr. Rolando A. Atiga or Dr. John Feeney under Optum Southwest Valleys, Optum Beaver California Oaks, IEHP Direct, Molina Direct or Alphacare medical group at the time of service. If you are not assigned to our office, you will be responsible for the charges should your insurance deny payment. Please notify the office as soon as there is a change in your insurance coverage so we can bill correctly.

OFFICE FINANCIAL POLICIES

- I understand that I am financially responsible for all charges for medical services rendered regardless of insurance coverage.

- I understand that I am responsible for any office visit copayment, co-insurance or deductible and this amount is due at the time of service.

- I understand that I must immediately pay any amounts over 30 days past due by an insurance company.

- I understand that amounts over 90 days past due are subject to collection procedures which could include small claims court or a 1-12% service charge per month on the unpaid balance.

- If this account is assigned to an attorney for collection and/or suit, a copy of the signature is valid as the original. Accounts sent to a collection agency will include an additional $25.00 transferring fee and proof of payment *to the collection agency* must be shown prior to additional services being rendered.

- If we bill an insurance company and is determined that you did not have coverage at the time of service being rendered you can pay $125 office visit rate (cash pay amount plus an administrative fee for billing services). If this amount is not paid, then the full amount will be billed and sent to collections with the same fees as noted in the above statements.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

(By signing above I am acknowledging that I have read both page 1 and 2 of the Office Financial Policies)

If other than patient, name of the person signing: _____

Relation to patient: _____

Payments can be made by:

- Calling the office with your payment information
- Online through your patient portal under “My Account” and “Current Statement”
- In office
- Mailing payment to: Atiga Family Practice- Billing, 25405 Hancock Ave, Ste 105, Murrieta, CA 92562

OFFICE POLICIES

Appointments:

- New patients are required to complete and return their new patient packets to our office prior to being scheduled. Once your forms are received by the office, a member of staff will contact you to schedule your appointment.
- Patients are required to be in our office 15 minutes prior to their scheduled appointment time. This allows our staff to complete the check-in process and obtain vital signs to ensure the patient is ready to be seen by their provider at their scheduled time.
- We set aside designated time for urgent and same day appointments. Please call as early as possible to obtain such an appointment when needed. If all same day appointments are filled, staff may direct you to an urgent care and/or the emergency room if necessary.
- If you are more than 15 minutes late to your scheduled appointment time, your appointment may need to be rescheduled to a different time and/or day to ensure other scheduled patients are seen in a timely manner.
- If you fail to keep your appointment and/or do not notify the office *by phone* at least 24 hours in advance of your scheduled appointment time you will be required to pay a No-Show fee of $50.00 for office visits or $25.00 for a nursing visit.
- If you no-show to 3 or more appointments within a 1-year period it will result in your being terminated from receiving patient care from our office.
- Your chart must be prepared for your appointment at least 24 hours in advance of the scheduled date and time or it will be cancelled. Our staff will try to reach you beginning 3-4 days prior to your scheduled visit to complete this.
  Chart prep includes:
  - confirming the appointment date, time, and location
  - reviewing all medications and allergies, which includes dosage and how often taken
  - conducting necessary screenings
  - updating medical history, which includes vaccinations, and outside procedures
  - Telemedicine appointment also require vital signs be obtained
- All visits require screenings that are billed to your insurance. These screenings are usually not covered by insurance but are required. Our office will not charge you for any screening codes that insurance does not cover.

OFFICE POLICIES

Appointments (continued):

- Annual wellness visits (for patients 15 months and younger the first 6 visits) include getting medical history, measurements, reviewing health risks by age/behaviors and other factors, health screenings/orders, immunizations and the provider making a personalized prevention plan to maintain your health. These visits do not include any discussion or treatment for new medical problems. Any items outside of these guidelines discussed during a wellness visit will be charged and covered according to your insurance's coverage guidelines. These visits require us to ask for updated forms about your health that are to be updated annually or you can schedule another appointment to review these additional items with your provider.
- Preventative care is part of treating the patient as a whole. It helps your provider with early detection of changes in your health and helps to monitor your health over a period of recommended time. Examples would be laboratory studies, diagnostic imaging/procedures. If you are continually non-compliant with your providers recommendations to access and monitor your health, it may result in you being terminated from receiving patient care from our office.

Prescriptions:

- On your visit to establish care, or when initially prescribed, our office will send your prescriptions to your pharmacy.
- For prescription refills you will need to contact your pharmacy and they will send our office an electronic request. ***Please note requests can take up to 48 business hours to process.***
- Notify the office of any change to your pharmacy information to ensure medications and supplies are sent to the correct facility.

Behavior:

- We do not tolerate rude or disrespectful behavior toward our staff or other patients, such as yelling and/or the use of profanity. Anyone behaving in such a manner will be asked to leave the office.
- Failure to comply and/or repeated incidents may result in termination of patient care from our office.
- You are encouraged to discuss your health concerns and review any questions regarding your plan of care with your provider. However, repeated non-compliance with agreed upon plan of care recommendations may result in termination of patient care.

OFFICE POLICIES

Forms and Medical Records Charges:

- If you would like a copy of your medical records, you can access them online without charge through the patient portal found online at AtigaFamilyPractice.com.
- If you need our office to print out your medical records, there is an administrative and supply fee of $25 and your records will be made available to you within 15 business days.
- Forms that the provider fills out at your request such as disability, utility company, school/work physical forms, etc. are subject to a $25 administrative and supply fee. Please allow up to 3 business days for completed forms to be made available to you.

After Hours:

If you need to be seen outside of our office hours you may go to the local emergency department or urgent care facility. You can also call our office and follow the prompts given in the message or visit our website, AtigaFamilyPractice.com, and go to the "About" tab to find "After Hours Instructions". Please only call the on-call doctor for advice ***on urgent matters only, the on-call doctor will not do prescription refills.***

I have read and understand pages 1 through 3 of the office policies. I agree to comply with the listed policies. I understand that failure to comply may result in termination of care from the office.

_____/_____ _____/_____

Patient Name DOB Patient or Authorized Representative Signature/ Date

If other than patient signing, state relationship: _____

TELEHEALTH POLICY IMPLEMENTATION

(Telehealth includes telemedicine, or any other name given for an appointment that is via audio, video, phone, and/or computer vs being physically present in the office)

1. I agree to receive health care services via telehealth. I understand that:
    a. I have the right to access Medi-Cal covered services, and all other insurances contracted with Atiga Family Practice, through an in-person, face-to-face visit or through telehealth.
    b. The use of telehealth is voluntary, and I may withdraw my consent to, or stop receiving services through telehealth at any time without affecting my ability to access covered services in the future.
    c. For Medi-Cal patients: Medi-Cal provides coverage for transportation services to in-person services when other resources have been reasonably exhausted.
    d. There may be limitations or risks related to receiving services through telehealth as compared to an in-person visit.
2. I understand that if I choose to have my medical appointment through telehealth that it is Atiga Family Practices' office policy that my chart be prepared by their office staff no later than twenty-four business hours prior to my scheduled appointment time. If I do not complete the chart prep when called by the office, return a call to the office to complete the chart prep, or decline to give vital signs, review medications or other needed information to office staff within this time my appointment can be cancelled, and I will be asked to reschedule.
3. I understand that for safety issues I cannot be driving during my telelehealth visit. If it is determined that I am operating a motor vehicle, my provider can end the appointment immediately and I will need to contact the office to reschedule my appointment and my telehealth appointment and chart preparation time completed will be billed accordingly.
4. I have read this document carefully, understand the potential limitations and risks of receiving services via telehealth , and have had my questions answered to my satisfaction.

If you have a copayment or are a cash pay patient payments can be made ahead of your scheduled appointment by:

* Calling the office with your payment information
* Going online through to patient portal under "My Account" and "Current Statement"
* Paying in office
* Mailing payment to: Atiga Family Practice: Billing
  25405 Hancock Ave, Ste 105
  Murrieta, CA 92562

Patients Name: _____ DOB: _____

Patients Signature: _____

If other than patient, name of the person signing: _____

Relation to patient: _____

(12/11/2023)

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated**: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether bron or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right ti arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation**: This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect**: If patient intends this agreement to cover services rendered before the date it is signed, patient should initial: _____ Effective as of the date of first medical services rendered.

If any provision if this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Physician's Signature or Authorized Representative's (Date)

Atiga Family Practice *aka*
Rolando A Atiga MD, A Professional Corp.

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____ _____
Print Patient's Name (DOB)

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to patient. Original is to be filed in Patient's medical records.

AB-1278 Physicians and surgeons: payments: disclosure: notice.

*The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at **openpaymentsdata.cms.gov**.*

Assembly Bill No. 1278

CHAPTER 750

An act to add Article 6.5 (commencing with Section 660) to Chapter 1 of Division 2 of the Business and Professions Code, relating to healing arts.

[Approved by Governor September 29, 2022. Filed with Secretary of State September 29, 2022.]

Legislative Counsel' s Digest

AB 1278, Nazarian. Physicians and surgeons: payments: disclosure: notice.

Existing law, the Medical Practice Act, establishes the Medical Board of California within the Department of Consumer Affairs and sets forth its powers and duties relating to the licensure and regulation of physicians and surgeons. Existing law establishes the Osteopathic Medical Board of California within the department and sets forth its powers and duties relating to the licensure and regulation of osteopathic physicians and surgeons.

Existing federal law known as the Open Payments program requires, among other things, applicable manufacturers of drugs, devices, and biological or medical supplies to annually report to the federal Secretary of Health and Human Services certain payments and other transfers of value made to covered recipients, as defined. The federal Centers for Medicare and Medicaid Services makes this Open Payments data available to the public via a federal government internet website.

Existing law, the Sherman Food, Drug, and Cosmetic Law, regulates the packaging, labeling, and advertising of drugs and devices, and is administered by the State Department of Public Health. That existing law specifically regulates drug marketing practices and requires a pharmaceutical company to adopt and update a program that includes policies on interactions with health care professionals and limits on gifts and incentives to medical or health professionals, as defined. Existing law requires each pharmaceutical company to establish in its program a specific annual dollar limit on gifts, promotional materials, or items or activities that the pharmaceutical company may give or otherwise provide to an individual medical or health care professional, with certain exemptions.

This bill would require a physician and surgeon, defined to include a physician and surgeon licensed pursuant to the Medical Practice Act or an osteopathic physician and surgeon licensed by the Osteopathic Medical Board of California under the Osteopathic Act, to provide to a patient at the initial office visit a written or electronic notice of the Open Payments database, as prescribed.

This bill would require a physician and surgeon to post an Open Payments database notice, as described, in each location where the licensee practices 91 and in an area that is likely to be seen by all persons who enter the office. The bill would, beginning January 1, 2024, require a physician and surgeon to conspicuously post the same Open Payments database notice on the internet website used for the physician and surgeon's practice, if such a website is used, except as provided. If the physician and surgeon is employed by a health care employer, the bill would instead require the health care employer to comply with these posting requirements.

This bill would define other terms for its purposes. A violation of the bill's provisions would constitute unprofessional conduct. The bill would specify that these provisions do not apply to a physician and surgeon working in a hospital emergency room.

The people of the State of California do enact as follows:

SECTION 1. Article 6.5 (commencing with Section 660) is added to Chapter 1 of Division 2 of the Business and Professions Code, to read:

Article 6.5. Open Payments Database Notices

660. For purposes of this article, all of the following definitions apply:

(a) "Drug or device company" means a manufacturer, developer, or distributor of pharmaceutical drugs or any device used in the context of the physician and surgeon's or osteopathic physician and surgeon's practice.

(b) "Health care employer" means an employer that provides health care services and that employs a physician and surgeon or an osteopathic physician and surgeon.

(c) "Open Payments database" means the database created to allow the public to search for data provided pursuant to Section 1320a-7h of Title 42 of the United States Code and that is maintained by the federal Centers for Medicare and Medicaid Services.

(d) "Physician and surgeon" includes a physician and surgeon licensed pursuant to the Medical Practice Act (Chapter 5 (commencing with Section 2000)) or an osteopathic physician and surgeon licensed by the Osteopathic Medical Board of California under the Osteopathic Act.

661. (a) A physician and surgeon shall provide to each patient at the initial office visit a written or electronic notice of the Open Payments database. The written notice shall include a signature from the patient or a patient representative and the date of signature.

(b) The written or electronic notice shall contain the following text: "The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov."

(c) A physician and surgeon shall include in the electronic records for the patient a record of the notice pursuant to this section.

(d) If a physician and surgeon does not maintain electronic records, the physician and surgeon shall include the notice pursuant to this section in the written records. (e) A physician and surgeon shall give to the patient or patient representative a copy of the signed and dated notice.

663. (a) (1) Notwithstanding any law, except as provided in subdivision (c), a physician and surgeon shall post in each location where the physician and surgeon practices, in an area that is likely to be seen by all persons who enter the office, an Open Payments database notice.

(2) The Open Payments database notice described in paragraph (1) shall include both of the following:

(A) An internet website link to the Open Payments database.

(B) The following text:

"For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public."

(b) Beginning January 1, 2024, if an internet website is used for a physician and surgeon's practice, then the physician and surgeon shall conspicuously post the Open Payments database notice described in subdivision (a) on that internet website, except as otherwise authorized under subdivision (c).

(c) Notwithstanding subdivisions (a) and (b), if a physician and surgeon subject to this section is employed by a health care employer, the health care employer shall be responsible for meeting the requirements of this section.

(d) A posting required by this section may be placed within the same notice posted by the physician and surgeon in accordance with Section 138 or 2026.

664. A violation of this article shall constitute unprofessional conduct.

665. This article does not apply to a physician and surgeon working in a hospital emergency room.

Patient Name:_____ DOB:_____ Date signed:_____

ATIGA FAMILY PRACTICE

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION TO OTHERS

Patients Name: _____ DOB: _____

I give permission for Atiga Family Practice to provide my personal health information checked below

☐ Scheduling/Appointment information

☐ Medical information, including symptoms, diagnosis, medications, and treatment plan

☐ Health information, including symptoms, diagnosis, medications, and treatment plan regarding
(* items below must be checked, or this information cannot be given);
☐ Substance abuse ☐ Behavioral health ☐ Developmental disability ☐ HIV/AIDS

☐ Lab/Test results

☐ Billing and payment information

☐ All health information (* Protected health information items must be checked to give this information)

to the below named individuals/companies:

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Authorization expires one year from the date of signature unless an alternate date is given.
Alternate date of expiration: _____

- I understand that my signature is required to release my personal information, to include photo identification, social security number, insurance information, demographics and medical history and treatment to others except in those circumstances where Atiga Family Practice is permitted or required by law to release this information. For example, Atiga Family Practice may release copies of this information to other health care providers, health plans, governmental agencies, and workers compensation carriers. Additionally, I understand that Atiga Family Practice is required by law to report certain diagnosis to the California Department of Public Health such as seizures, cancer, and the diagnosis of a communicable disease(s).
- I understand that this permission will remain in effect until the date stated above or until such time as I *revoke it in writing* (an updated agreement form will also revoke the validity of this specific agreement).

_____ _____
Patient/Authorized Representative Signature Date

If other than patient signing, state relationship: _____

(12/03/21)

AUTHORIZATION TO OBTAIN INFORMATION FROM OUTSIDE HEALTH CARE PROVIDERS

This authorization allows the healthcare provider(s) named below to release confidential medical information and records regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis, or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax, or other electronic methods to:

ATIGA FAMILY PRACTICE
Fax: 951-695-4689 or 877-254-0566

25405 Hancock Ave, Suite 105	**29826 Haun Rd, Suite 201**
Murrieta, Ca 92562	**Menifee, Ca 92586**
Ph: 951-695-4688	**Ph: 951-381-8150**

The medical information/records are being requested for the purpose of continuity of patient care.

I hereby authorize: _____
Physician/Healthcare Facility Phone Number

To release the below indicated medical information:

(___) Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment unless marked below)
(___) Limited to the following: _____

I also consent to the specific release of the following records:
Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.

(___) Drug/ Alcohol/Substance Abuse
(___) Psychiatric/Mental Health
(___) Test results for Genetic Testing
(___) HIV/AIDS Diagnosis/Treatment
(___) Test results for antibodies to HIV/AIDS

DURATION: This authorization shall be effective immediately and remain in effect for one year from the date of signature below or until: _____

RESTRICTIONS:
Permissions for future use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such a disclosure is specifically required or permitted by law.

A photocopy of this facsimile for authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____ _____
Signature of Patient *or legal/personal representative* Date *Relationship if other than patient*

_____ _____
Patients Name (PRINT) DOB

(12/03/21)

ATIGA FAMILY PRACTICE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. (Please request a copy from our staff or visit Atiga Family Practice.com, go to "Patients" tab and select "Forms" to download/view the "HIPPA NOTICE OF PRIVACY PRACTICES". A copy of this signed, dated document shall be as effective as the original.

_____ _____

Patients Name DOB

_____ _____

Patient *or Authorized Representatives* Signature Date

_____ _____

If Other Than Patient, Name of Person Signing Relation to patient

- I authorize contact from this office to confirm my appointments, treatment and billing information via the contact information provided on my registration form.

  I choose to *opt out* of receiving confirmation notices (___)

- I authorize contact from this office to be informed about special services, events, fund raising efforts or new health information via the e-mail address provided on my registration form.

  I choose to *opt out* of receiving promotional and health information notices (___)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer,

__ I have entered into patients electronic health record their preferred choices or

I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

__ It was emergency treatment, and I could not communicate with the patient
__ The patient refused to sign
__ The patient was unable to sign because
__ Other (please describe) _____

_____

Signature of Privacy Officer

12/03/2021

ATIGA FAMILY PRACTICE

ADVANCE HEALTHCARE DIRECTIVE STATUS

Patient Name: _____ **DOB:** _____

Please check all that apply:

( ) I have previously completed an Advance Health Care Directive and have provided a copy for inclusion into my health records. *Staff who scanned documents:* _____

( ) I have previously completed an Advance Health Care Directive which is on file with: _____ , and I give them permission to release a copy of this document to Atiga Family Practice. *Staff who requested records*: _____

( ) I have previously executed an Advance Health Care Directive but would like information/forms to update my directive. *Staff signature:* _____

( ) I have not executed an Advance Health Care Directive and would like further information/forms to do so. *Staff signature:* _____

( ) I have not previously executed an Advance Health Care Directive and would like to discuss this further with my primary care provider. *Provider signature :* _____

( ) I have not previously executed an Advance Health Care Directive and am not interested in receiving any further information at this time.

I acknowledge that the provider or staff member has provided me with information concerning an Advance Health Care Directive and that:

1) I am 18 years or older or am legally able to make healthcare decisions without parental/guardian consent.
2) I have been informed of my right to formulate and execute an Advance Health Care Directive.
3) I understand that it is my responsibility to provide this office with documents that are required to carry out my Advance Health Care Directives.
4) I am aware that an Advance Health Care Directive may be included within any of the following:
    a. A Durable Power of Attorney for Health Care.
    b. The "Declaration" in A Natural Death Act. (Ex: Living Will)
    c. I may write down my wishes on a piece of paper that my family may use in deciding my medical treatment, in the event I should become unable to do so. I understand that this paper must be appropriately witnessed or notarized to be legally valid.

Patient or *Authorized Representative* signature: _____ **Date:** _____

***If other than patient signing, Name and Relation to patient*:** _____

Rolando A. Atiga, M.D. APC ATIGA FAMILY PRACTICE ***www.AtigaFamilyPractice.com***

25405 Hancock Avenue, Suite 105
Murrieta, California 92562
Phone: (951)695-4688

29826 Haun Road, Suite 314
Menifee, California 92586
Phone: (951) 381-8150

Fax: (877) 254-0566

Name:_____ **DOB:**_____

CONTROLLED SUBSTANCE MANAGEMENT AGREEMENT

The purpose of this agreement is to prevent any misunderstandings about certain medicines you will be taking for pain, insomnia, mental health and/or weight management. This is to help both you and your provider comply with the laws regarding controlled pharmaceuticals. This contract becomes effective if at any point you are prescribed a controlled substance by an Atiga Family Practice provider.

_____ I understand that this agreement is essential to the trust and confidence necessary in a provider/ patient relationship and that my provider undertakes to treat me based on this agreement.

_____ I understand that if I break this agreement, my provider will stop prescribing my controlled medications. In this case, my provider will taper off the medications over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug dependence program may be recommended.

_____ I will communicate fully with my provider about the character and intensity of my medical condition(s) and the effect/relief they have on my daily life. My provider will assess the risk, benefit, and safety of my medications to include side effects, functional abilities, and efficacy.

_____ I agree that I will submit to random blood or urine testing a minimum of 2 times per year, when requested by my provider, or if required by my pharmacy, to determine my compliance with my controlled substance management agreement. I also understand that not all insurances cover the cost of drug screenings and I may be responsible for all or part of the laboratory bill.

_____ I will not combine any controlled medications with illegal, street, or recreational drugs. Any drug screen that is positive for both prescribed controlled substances and illicit substances will be considered a violation of this contract.

_____ I will not share, sell, or trade my medications with anyone.

_____ I will not attempt to obtain or fill any prescription for a controlled medication, including opioid pain medications, controlled stimulants, or antianxiety medications from any other provider that is not affiliated with Atiga Family Practice, unless there is a contract formed with a specialist.

_____ I will safeguard my controlled medications from loss or theft. Lost or stolen medications will not be replaced.

Name:_____ DOB:_____

_____ I agree that refills of my controlled substance prescriptions will be made only at the time of an office visit or during regular office hours, as indicated by office policy. ***No refills will be available after hours including weekends.***

_____ I will call the pharmacy for refill requests *3 business days prior* to the date of the next refill due date, but the refill will be sent or prescription ready for pick up the date that the medication is due to be filled. If the refill date falls on a weekend the prescription will be sent or the prescription ready for pick up the Friday the medication will be due for refill.

_____ I understand that I must have an office visit prior to any medication changes.

_____ I understand that I am responsible for making and keeping appointments for controlled substance follow ups at least every 3 months, or sooner if my provider recommends, to be re-evaluated and that my medications will not be filled until my provider has re-evaluated me.

_____ I authorize the provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my provider to provide a copy of this agreement to my pharmacy. I agree to waive any applicable or right of privacy or confidentiality with respect to these authorizations.

_____ I agree that I will take my medications exactly as prescribed. I am NOT allowed to change the dose or number of times per day I take my medications and doing so will result in my being without medications for a period of time and considered a violation of this contract.

_____ I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been answered and **a copy of this document has been given to me**.

_____ I understand that ANY deviation from the above conditions can be grounds for the provider to discharge me from the practice.

Consequence of not signing this contract are that providers of Atiga Family Practice will not prescribe any controlled substances for you.

This agreement is effective on (today's date): _____
and remains effective as long as you are being prescribed controlled medications.

Patient Signature: _____ Date: _____

Physician/Provider Signature: _____ Date: _____

ADULT HEALTH HISTORY

Name/Nombre:	Age/Edad:	DOB/Fecha de nacimiento:	Today's Date/Fecha:

Past Medical Diagnosis/Diagnóstico médico anterior:

Place a check mark next to those you have currently or have had or check none/

Coloque una marca de verificación junto a las que tiene actualmente o que no ha tenido o marque ninguna

None/Ninguno ○

	Alcohol or Substance Abuse/ Abuso de alcohol o sustancias			HIV or AIDS/ VIH o SIDA
	Anemia			High cholesterol/ Cholesterol alto
	Anxiety/ Ansiedad			High blood pressure (HTN)/ Hipertensión
	Arthritis/ Arthritis			Hypo or Hyperthyroidism/ Hipo o hipertiroidismo
	Asthma/ Asma			Gastrointestinal disease/ Enfermedad gastrointestinal
	Blood transfusion/ Transfusion de sangre			Kidney disease/ Enfermedades renales
	Benign Prostatic Hypertrophy (BPH)/ Prostática benigna			Liver disease/ Enfermedad del higado
	Cancer			Measles/ Sarampión
	Cataracts/ Cataratas			Mental Illness/ Enfermedad mental
	Chickenpox/ Varicela			Mumps/ Paperas
	Congestive Heart Failure (CHF)/ Insuficiencia cardiaca			Nerve or Muscle disease/ Enfermedad de los nervios o músculos
	COPD (lung disease)/ Enfermedad pulmonar			Osteoporosis
	Depression/ Depression			Rheumatic fever/ Fiebre reumática
	Diabetes			Seizures/ Convulsiones
	GERD (heartburn)/ Reflujo ácido			Sexually Transmitted disease/ Enfermedades de transmisión sexual
	Glaucoma			Sickle Cell disease/ Enfermedad de célula falciforme
	Headaches/ Dolores de cabeza			Sleep Apnea/ Apnea del sueño
	Heart disease/ Cardiopatía			Stroke/ Carrera
	Heart attack/ Infarto de miocardio			Tuberculosis (TB)

Other (list)/ Otras (lista):

Review of Systems: *Circle which symptoms you currently have or circle none*

Revisión de sistemas: ***E****ncierre en un círculo los síntomas que tiene actualmente o rodear ninguno*

General	Fever/ Fiebre Decreased energy/ Disminución de energía Loss of appetite/ Pérdida de apetito Unintended weight loss or gain/ Pérdida o aumento de peso involuntario	None
Head/ Cabeza	Headache/ Dolor de cabeza Injury/ Lesión	None
Eye/ Ojo	Visual change/ Cambio visual Discharge/ Descarga Redness/ Enrojecimiento Itching/ Picor Swelling/ Hinchazón	None
Ear/ Oido	Difficulty hearing /Dificultad para oír Pain/Delor Discharge/ Descarga	None
Nose/ Nanz	Runny nose/ Nariz que moquea Congestion Bleeding/ Sangrado	None
Mouth/Throat/ Boca / Garganta	Sore throat/ Dolor de garganta Difficulty swallowing/ Dificultad para tragar Dental problems/ Problemas dentales	None
Lung/ Pulmones	Shortness of breath/ Dificultad para respirar Coughing/ Tosiendo Chest pain/ Dolor de pecho Wheezing/ Sibilancias Phlegm/ Flema	None
Heart/ Corazon	Chest pain/ Dolor de pecho Feeling faint/ Sensación de desmayo Swelling of arms or legs/ Hinchazón de brazos o piernas	None

NAME: _____ **DOB:** _____

Stomach -Bowel/ Estomago - Intestinos	Abdominal pain/ Dolor abdominal Nausea Vomiting/ Vomitando Diarrhea Constipation/ Estreñimiento Bloating/ Hinchazón Blood in stool/ Sangre en las heces	None
Genitourinary/ Gentiurinario	Painful urination/ Dolor al orinar Incontinence Discharge/ Descarga Feeling of incomplete bladder emptying/Sensación de vaciado incompleto de la vejiga difficult to urinate/ dificultad para orinar blood in urine/ sangre en la orina	None
Mental Health/ Salud mental	Mood changes/ Cambios de humor Nervousness/ Nerviosismo Tension Unable to sleep/ Incapaz de dormir	None
Musculoskeletal/ Musculos - Huesos	Pain/Dolor Swelling/ Hinchazón Change in skin color/ Cambio en el color de la piel Difficulty moving/ Dificultad para moverse Falls/ Caídas	None
Neurologic/Nervious	Dizziness/ Mareo Weakness/ Debilidad Hands shaking/ Manos temblorosas Seizures/ Convulsiones	None
Skin/ Piel	Rash/ Erupción Itching/ Comezón Color change/ Cambio de color Easy bruising or bleeding/ Fácil aparición de hematomas o sangrado New mole/ Nuevo lunar Change in a mole/ Cambio en un lunar	None

Surgical History/ Historial quirúrgico

Place a check mark next to those you have had or check none/
Coloque una marca de verificación junto a las que ha tenido o marque ninguno None/Ninguno ○

	Appendectomy/ Apendectomía
	Bariatric Surgery/ Cirugía bariátrica
	Bladder Surgery/ Cirugía de vejiga
	Brain Surgery/ Cirugía cerebral
	Cholecystectomy (removal of gallbladder)/ Colicistectomía (extirpación de la vesícula biliar)
	Colon Surgery/ Cirugía de Colon
	Eye Surgery/ Cirujía de ojo
	Heart Surgery/ Cirugía de corazón
	Hernia Repair/ Reparación de hernia
	Joint Replacement/ Reemplazo de la articulación
	Spinal surgery/ Cirugía de la columna
	Tonsillectomy or Adenoidectomy/ Tosilectomía o adenoidectomía

	Women/ mujeres:
	Hysterectomy/ Histerectomía
	☐ Ovaries removed/ Se extirparon los ovarios
	☐ Ovaries remain/ Los ovarios permanecen
	Tubal ligation (tubes tied)/ Ligadura de trompas
	Mastectomy/ Mastectomía
	☐ Right/Derecho ☐ Left/ Izquierdo ☐ Both/ Ambos

	Men/ Hombres:
	Prostate Surgery/ Cirugía de próstata
	Vasectomy

Other Surgeries (list)/ Otras cirugías (lista):

Vaccinations/ Vacunas:

None/Ninguno ○

Vaccine/Vacuna	Last recieved/ Última fecha dada
Covid-19	
Flu/ Gripe	
Pneumonia/ Pneumonia	
Shingles/ Herpes	
Tetanus/ Tétanos	

Screenings and date last completed/ Proyecciones o fecha de finalización por última vez

Eye exam/ Examen de la vista: _____ Colonoscopy/ Colonoscopia: _____
Bone Density Study/ Estudio de densidad ósea: _____
None/Ninguno ○

NAME: _____ **DOB:** _____

Family History/ Historia familiar:

Place a check in the box for family members who have or had the problem listed/
Coloque una marca en la casilla para los miembros de la familia que tienen o tuvieron el problema en la lista

☐ Adopted or unknown family history/ Antecedentes familiares adoptados o desconocidos

	Diabetes	Hypertension	Heart Disease/ Cardiopatía	Stroke/ Carrera	Mental Illness/ Enfermedad mental	Cancer
Mother/Mamá						
Father/Padre						
Child/ Niñas o niños						
Grandparent/ Abuela o abuelo						
Aunt or Uncle/ Tía o tio						
Unknown/ Inseguro de						

Social History/ Historia social:

☐ Married/ Casado ☐ Single/ Solero ☐ Separated/ Separado ☐ Divorced/ Dicorciado ☐ Widowed/ Viudo

Occupation/ Ocupación: _____

Years of education/ Años de educación: _____

Housing/ Alojamiento: ☐ Homeless/ Sin hogar ☐ Apartment or Condo ☐ Mobile Home/ Casa móvil
☐ RV/ Vehículo recreacional ☐ House/ Casa ☐ Assisted living/ Vida asistida
☐ Skilled Nursing/ Enfermería especializada ☐ Residential care/ Atención residencial
☐ Live alone/ Vivir solo ☐ Live with family or friends/ Vivir con familiares o amigos

Do you have children living with you?/ ¿Tiene hijos viviendo con usted? ☐ Yes/ Sí ☐ No How many? _____

Tobacco and Drugs/ Tabaco y Drogas

Do you use drugs for other than medical purposes? / ¿Usa drogas para otros fines que no sean médicos?
☐ Yes/ Sí ☐ No
How often? / ¿Con qué frecuencia _____
What do you use? / ¿Que usas? _____
Have you ever injected drugs? / ¿Alguna vez te has inyectado drogas? ☐ Yes/ Sí ☐ No

Check one of the following about tobacco products/ Marque una de las siguientes opciones sobre productos de tabaco:

☐ Never smoked – skip to the next section/ Nunca fumé: pase a la siguiente sección

☐ Former Smoker – answer below questions/ Ex fumador: responda las siguientes preguntas
How long has it been since you last smoked? / ¿Cuánto tiempo ha pasado desde la última vez que fumó?
☐ Less than 1 month/ Menos de 1 mes ☐ 1 -3 months/ meses ☐ 3-6 months/ meses
☐ 6-12 months/ meses ☐ 1-5 years/ años ☐ 5-10 years/ años ☐ Over 10 years/ Mas de 10 años

How many cigarettes per day did you smoke? / ¿Cuántos cigarrillos fumaba al día? _____
How long did you smoke? / ¿Cuánto tiempo fumaste? _____

NAME: _____ **DOB:** _____

☐ Current smoker - answer the below questions/ Actual fumador: responda las siguientes preguntas

How soon after waking do you smoke? / ¿Qué tan pronto después de despertar fuma?

☐ Within 5 minutes/ En 5 minutos ☐ 6-30 minutes/ minutos ☐ 30-60 minutes/ minutos

☐ Over an hour/ Mas de una hora

How many cigarettes per day do you smoke? / ¿Cuántos cigarrillos fuma al día? _____

At what age did you start smoking? / ¿A qué edad empezaste a fumar? _____

Are you ready or considering quitting? / ¿Estás listo o considerando dejar de fumar? ☐ Yes/ Sí ☐ No

Do you/ Vos si: ☐ Chew tobacco/ Masticar tabaco ☐ Smoke cigars/ Fumar puros

☐ Smoke a tobacco pipe/ Fumar una pipa de tabaco ☐ Vape ☐ E-cigarettes/ Cigarrillos electrónicos

Alcohol

Do you ever drink alcohol? / ¿Bebes alcohol alguna vez?

☐ Yes – complete all questions / Sí – completar todas las preguntas

☐ No – skip to next section/ pasar a la siguiente sección

Please indicate for each of the below items how much you drink each week:

Indique para cada uno de los siguientes elementos cuánto bebe cada semana:

Glasses of wine/ Vasos de vino: _____ Can or bottles of beer/ Lata o botellas de cerveza: _____

Shots of liquor/ Tragos de licor: _____ Mixed alcoholic drinks/ Bebidas alcohólicas mixtas: _____

Sexual Activity/ Actividad sexual:

Have you had sex in the past 12 months? / ¿Ha tenido relaciones sexuales en los últimos 12 meses?

☐ Yes/ Sí ☐ No- skip to next section/ pasar a la siguiente sección

With/ Con: ☐ Women only/ Mujeres ☐ Men only/Hombres ☐ Both women and men/ Mujeres como hombres

☐ One partner only/ Uno socio ☐ Multiple partners/ Múltiples socios

Do you use birth control? / ¿Usas anticonceptivos? ☐ Yes/ Sí ☐ No

If yes, what type?/ Si es así, ¿de qué tipo? ☐ Condoms/ Condones ☐ Oral contraceptives/ Anticonceptivos orales

☐ IUD/ DIU ☐ Implant ☐ Shot/ Inyección ☐ Vaginal ring/ Anillo vaginal ☐ Spermicide/ Espermicida

☐ Withdraw/ Retirar ☐ Other (list)/ Otra (lista): _____

Do you have a new sexual partner? / ¿Tienes una nueva pareja sexual? ☐ Yes/ Sí ☐ No

Excercise/ Ejercicio:

On average how many times per week do you engage in moderate to strenuous physical activity?

En promedio, ¿cuántas veces a la semana realiza una actividad física de moderada a extenuante?

☐ Never/ Nunca ☐ 1-2 days/ dias ☐ 3-4 days/ dias ☐ 5-6 days/ dias ☐ Every day/ Diario

Safety/ Seguridad:

Do you need assistance with any of the following? / ¿Necesita ayuda con alguno de los siguientes?

☐ Bathing/ Baños ☐ Dressing/ Vendaje ☐ Eating/ Comiendo

☐ Getting from bed to chair/ Ir de la cama a la silla ☐ Toileting/ Aseo

Do you have urinary and/or bowel incontinence? / ¿Tiene incontinencia urinaria y / o intestinal? ☐ Yes/ Sí ☐ No

Do you use any of the following? / ¿Utiliza alguno de los siguientes? ☐ Cane/Caña ☐ Walker/ Caminante

☐ Wheelchair/Silla de ruedas ☐ Scooter ☐ Hospital bed/ Cama de hospital

☐ Nighttime breathing device/ Dispositivo de respiración nocturna ☐ Oxygen/ Oxígeno

Patient Signature/ Firma del paciente _____

Provider Signature/ Firma del proveedor _____

ATIGA FAMILY PRACTICE

TUBERCULOSIS (TB) RISK ASSESSMENT

Date/Fecha: _____
Patient Name/ **DOB/**
Nombre del paciente: _____ **Fecha de nacimiento: _____**

Do you have a history of positive TB test or TB disease?
¿Tiene antecedentes de prueba de TB positiva o enfermedad de TB? ( ) Yes/ Sí ( ) No

If yes/En caso afirmación,

Have you had a chest x-ray in the last 6 months? / ( ) Yes/ Sí ( ) No
¿Se ha hecho una radiografía de tórax en los últimos 6 meses?

Did you receive treatment? / ¿Recibió tratamiento? ( ) Yes/ Sí ( ) No

1. Are you experiencing any signs and symptoms of TB? ( ) Yes/ Sí ( ) No
   (prolonged cough, coughing up blood, fever, night sweats, weight loss or excessive fatigue) /
   ¿¿Está experimentando algún signo y síntoma de TB?
   (tos prolongada, tos con sangre, fiebre, sudores nocturnos, pérdida de peso o fatiga excesiva)
2. Have you had close contact with someone who has TB? / ( ) Yes/ Sí ( ) No
   ¿Ha tenido contacto cercano con alguien que tiene un diagnóstico confirmado o sospechoso de TB?
3. Are you from Asia, Africa, Central America, or South America? / ( ) Yes/ Sí ( ) No
   ¿Eres de Asia, África, América Central o América del Sur?
4. Do you live in a facility (nursing home, rehab…)? / ( ) Yes/ Sí ( ) No
   ¿Vives en un centro (residencia de ancianos, rehabilitación...)?
5. Have you traveled to an area of high TB prevalence?
   (Asia, Africa, Central or South America) / ( ) Yes/ Sí ( ) No
   ¿Ha viajado a un área de alta prevalencia de TB? (Asia, África, América Central o del Sur)
6. Have you or anyone you live with been incarcerated in the last 5 years? / ( ) Yes/ Sí ( ) No
   ¿Usted o alguien con quien vive ha estado encarcelado en los últimos 5 años?
7. Do you live with, or are you frequently exposed to anyone who is homeless, a migrant farm worker, user of street drugs or a resident in a facility? / ( ) Yes/ Sí ( ) No
   ¿Vive con, o está frecuentemente expuesto a cualquier persona sin hogar, un trabajador agrícola migrante, usuario de drogas callejeras o residente en una instalación?

You may be at increased risk for TB if you answered YES to any of the above questions. Persons at increased risk for TB should have a yearly TB test. Testing can be done by either skin test or blood work. A positive test for either of these should be followed by a CXR./
Usted puede estar en mayor riesgo de TB si respondió SÍ a cualquiera de las preguntas anteriores. Las personas con mayor riesgo de TB deben hacerse una prueba anual de TB. Las pruebas se pueden realizar mediante un análisis de la piel o un análisis de sangre. Una prueba positiva para cualquiera de estos debe ser seguida por una radiografía de tórax.

Date of last TB screening / Date de la última prueba de detección de la tuberculosis: _____
( ) Unknown/ Desconocido ( ) No previous testing/ Sin pruebas previas

Last screening done by/ Última evaluación realizada por:
( ) PPD skin test/ prueba cutánea ( ) Chest X-Ray/ radiografía de tórax ( ) Blood draw/ Extracción de sangre

Results were/ Los resultados fueron : ( ) Positive/ Positivo ( ) Negative/ Negativo

ATIGA FAMILY PRACTICE

PATIENT NAME/ **DOB/**

Nombre del paciente: _____ **Fecha de nacimiento: _____**

MEDICATIONS/MEDICAMENTOS

****Please list ALL medicine you take including over the counter and supplements/**
Por favor, enumere TODOS los medicamentos que toma incluyendo sobre el mostrador y suplmentos

Name/ el nombre	Dose/ la dosis	How often/ con que frecuencia	Taking for/ Tomar para	Prescriber/ Prescriptor

ALLERGIES TO MEDICATION/ALERGIAS A LA MEDICACIÓN

Name of Medicine/ Nombre de la Medicina	Type of Reaction/ tip de reaccion

DURABLE MEDICAL EQUIPMENT/EQUIPO MÉDICO DURADERO

List any medical equipment you use at home? (Ex: CPAP, glucometer etc.)/
Enuniere cualguier equipo medico que use en casa (por ejemplo: CPAP, glucómetro, etc.)

Staying Healthy Assessment

Adult

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ Other (*Specify*)		Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Are you concerned about your weight?	No	Yes	Skip	
8	Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day?	Yes	No	Skip	Physical Activity
9	Do you feel safe where you live?	Yes	No	Skip	Safety
10	Have you had any car accidents lately?	No	Yes	Skip	
11	Have you been hit, slapped, kicked, or physically hurt by someone in the last year?	No	Yes	Skip	
12	Do you always wear a seat belt when driving or riding in a car?	Yes	No	Skip	
13	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
14	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
15	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
16	Do you often have trouble sleeping?	No	Yes	Skip	
17	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
18	Do friends or family members smoke in your house or place where you live?	No	Yes	Skip	

Name:_____ DOB:_____

19	In the past year, have you had: ☐ **(men)** 5 or more alcohol drinks in one day? ☐ **(women)** 4 or more alcohol drinks in one day?	No	Yes	Skip	
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
21	Do you think you or your partner could be pregnant?	No	Yes	Skip	Sexual Issues
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
23	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
24	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
25	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
26	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
27	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

NAME: _____ **DOB:** _____

Adverse Childhood Experience Questionnaire for Adults

California Surgeon General's Clinical Advisory Committee

aces aware
SCREEN. TREAT. HEAL.

Our relationships and experiences—even those in childhood—can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

Instructions: Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday. Then, please add up the number of categories of ACEs you experienced and put the *total number* at the bottom.

Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	☐
Did you lose a parent through divorce, abandonment, death, or other reason?	☐
Did you live with anyone who was depressed, mentally ill, or attempted suicide?	☐
Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	☐
Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	☐
Did you live with anyone who went to jail or prison?	☐
Did a parent or adult in your home ever swear at you, insult you, or put you down?	☐
Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	☐
Did you feel that no one in your family loved you or thought you were special?	☐
Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	☐
Your ACE score is the total number of checked responses	

Do you believe that these experiences have affected your health? ◯ **Not Much** ◯ **Some** ◯ **A Lot**

Experiences in childhood are just one part of a person's life story.
There are many ways to heal throughout one's life.

Please let us know if you have questions about privacy or confidentiality.

Provider Signature: _____

5/5/20

PLEASE COMPLETE THE PHQ-9 AND GAD-7

Patient Name: _____ **DOB:** _____ **Date of Referral:** _____

PHQ9 **Over the last two weeks how often have you been bothered by the following problems?**		**0** Not at all	**1** Several Days	**2** More than half the days	**3** Nearly every day
A	Little interest or pleasure in doing things	☐	☐	☐	☐
B	Feeling down, depressed, or hopeless	☐	☐	☐	☐
C	Trouble falling or staying asleep, sleeping too much	☐	☐	☐	☐
D	Feeling tired or having little energy	☐	☐	☐	☐
E	Poor appetite or overeating	☐	☐	☐	☐
F	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
G	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
H	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
I	Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
Severity Score	Mild depression = 5 – 10 Moderate depression = 10 – 18 Severe depression = 19 – 27	Total Score:			
	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

GAD7 **Over the last two weeks how often have you been bothered by the following problems?**	**0** Not at all	**1** Several Days	**2** Over than half the days	**3** Nearly every day
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble relaxing	☐	☐	☐	☐
Being so restless that it's hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐
Total Score (add your column scores)				
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Providers signature: _____

Date: _____