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

HEALTH HISTORY FORM / FORMULARIO DE HISTORIAL DE SALUD (0-17 YO)

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

Name of person completing form/
Nombre de la persona que completa el formulario: _____

Relationship to patient/Relación con el paciente:
☐ Parent/Madre o Padre ☐ Grandparent/Abuela o Abuelo ☐ Sibling/Hermana o Hermano
☐ Other relative/Otro pariente ☐ Guardian/Guardiana oGuardián

Home information/ Información de la casa:

Whom does the patient reside with? / ¿Con quién reside el paciente?
☐ Parent/Madre o Padre ☐ Grandparent/Abuela o Abuelo ☐ Sibling/Hermana o Hermano
☐ Other relative/Otro pariente ☐ Guardian/Guardiana oGuardián

How many people reside in the home/Cuantas personas residen en el hogar: _____

Parents are/ Los padres son: ☐ Married/Casado ☐ Divorced/Divorciado ☐ Separated/Apartado ☐ Deceased/Fallecido

Is there drug, alcohol or smoking in the home?/¿Hay drogas, alcohol o fumar en casa? ☐ Yes/Sí ☐ No

History of pregnancy and birth/ Historia de embarazo y Nacimiento

☐ Patient is adopted or history is unknown (El paciente es adoptado o la historia es desconocida)

Method of delivery/Método de entrega: ☐ Vaginal ☐ C-Section/Cesárea
☐ Forcep or vacuum assisted/ Forcep o asistido por vacío

Method of feeding/Método de alimentación: ☐ Breastmilk/La leche materna ☐ Formula

Weight at birth/ Peso al nacer: _____ Length at birth/ Longitud al nacer: _____

	Yes - explain/ Sí - explicar	No
Any illness or problems during pregnancy? / ¿Dónde hubo alguna enfermedad o problema durante el embarazo?		
Any difficulties during pregnancy? / ¿Alguna dificultad durante el embarazo?		
Were alcohol or non-prescribed drugs used? / ¿Se consumió alcohol o drogas sin receta?		
Was the patient born before 37 weeks pregnancy? / ¿La paciente nació antes de las 37 semanas de embarazo?		
Was more than one infant delivered? / ¿Fue entregado más de un bebé?		
Were there any complications at birth? / ¿Hubo alguna complicación al nacer?		

NAME: _____ DOB: _____

Past Medical Diagnosis/Diagnóstico médico anterior:
Place a check mark next to those previously diagnosed with/
Coloque una marca de verificación junto a los diagnosticados previamente con

☐ None/Ninguno

	ADD, ADHD, Autism		HIV or AIDS/VIH o SIDA
	Alcohol or Substance Abuse/ Abuso de alcohol o sustancias		High cholesterol/Cholesterol alto
	Anemia		High blood pressure (HTN)/Hipertensión
	Anxiety/Ansiedad		Hypo or Hyperthyroidism/Hipo o hipertiroidismo
	Arthritis/Arthritis		Kidney disease/Enfermedades renales
	Asthma/Asma		Liver disease/Enfermedad del higado
	Blood transfusion/Transfusion de sangre		Measles/Sarampión
	Cancer		Mental Illness/Enfermedad mental
	Chickenpox/Varicela		Mumps/Paperas
	Depression/Depresión		Nerve or Muscle disease/ Enfermedad de los nervios o músculos
	Diabetes		Rheumatic fever/Fiebre reumática
	Eating disorder/Desorden alimenticio		Seizures/Convulsiones
	Frequent ear infections/ Infecciones frecuentes del oído		Sexually Transmitted disease/ Enfermedades de transmisión sexual
	GERD (heartburn)/Reflujo ácido		Sickle Cell disease/Enfermedad de célula falciforme
	Gastrointestinal disease/Enfermedad gastrointestinal		Sleep Apnea/Apnea del sueño
	Headaches/Dolores de cabeza		Stroke/Carrera
	Heart disease/Cardiopatía		Tuberculosis (TB) or positive test/o prueba positiva

Other (list)/ Otras (lista):

Review of Systems/Revisión de sistemas*:*
Place a checkmark next to symptoms being experienced/
Coloque una marca de verificación junto a los síntomas que experimenta

☐ None/Ninguno

	Allergies/Alergias		Muscle, joint, bone problems/ Problemas musculares, articulares y óseos
	Asthma, bronchitis, pneumonia/ Asma, bronquitis, neumonía		Nail biting, teeth grinding, thumb sucking/Morderse las uñas,rechinar los dientes,chuparse el dedo
	Bruising or bleeding issues/ Problemas de sangrado o hematomas		Sore throat/Dolor de garganta
	Constipation/Estreñimiento		Speech issues/Problemas del habla
	Convulsions, seizures, epilepsy/ Convulsiones, convulsiones, epilepsia		Skin problems/Problemas de la piel
	Dental problems/Problemas dentales		Stomachaches/Dolores de estómago
	Diarrhea, incontinence/Diarrea, incontinencia		Urinary problems, incontinence, bed wetting/ Problemas urinarios, incontinencia, enuresis
	Difficulty breathing or snoring at night/ Dificultad para respirar o roncar por la noche		Vision or eye problems/ Problemas de la vista o de los ojos
	Hearing or ear problems/ Problemas de audición o de oído		Vomiting after food, refusing to eat/ Vómitos después de la comida, negándose a comer
	Headaches, dizziness/Dolores de cabeza, mareos		***Girls only/Sólo niñas:***
			Started Menses/Menstruación comenzada
	Heart pounding, reapid pulse/ Latidos del corazón o pulso rápido		Problems with menstruation/ Problemas con la menstruación

NAME: _____ DOB: _____

Vaccinations/ Vacunas:

☐ **No previous vaccinations/ Sin vacunas previas**

****PLEASE PROVIDE OFFICE WITH COPY OF PREVIOUS VACCINATION****

**** POR FAVOR PROPORCIONE A LA OFICINA UNA COPIA DE LAS VACUNAS ANTERIORES ****

and TB test documents/y documentos de prueba de tuberculosis

Screenings/Proyecciones

Date last completed/Fecha de finalización por última vez

Eye exam/Examen de la vista: _____

☐ No previous eye exam/Sin examen ocular previo

Hearing Screen/Pantalla de audición: _____

☐ No previus hearing exam/ Sin examen auditivo previo

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 member/Familiar desconocido						

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

NAME: _____ DOB: _____

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? _____

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

How long did you smoke?/¿Cuánto tiempo fumaste? _____

☐ 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?

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

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

What and how often do you drink?/¿Qué bebe y con qué frecuencia? _____

Sexual Activity/Actividad sexual:

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

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

☐ Yes/Sí

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

What type?/¿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 more than one sexual partner?/¿Tiene más de una pareja sexual? ☐ Yes/Sí ☐ No

Have you had a STD screening/¿Ha tenido una prueba de detección de ETS?: ☐ Yes/Sí ☐ No

Last done/Last done: _____

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

Signature/Firma _____

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

9 – 11 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	Grade in School:

Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)	School Attendance Regular? ☐ 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	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip	
3	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Does your child drink more than one cup (8 oz.) of juice per day?	No	Yes	Skip	
5	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
6	Does your child exercise or play sports most days of the week?	Yes	No	Skip	Physical Activity
7	Are you concerned about your child's weight?	No	Yes	Skip	
8	Does your child watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
9	Does your home have a working smoke detector?	Yes	No	Skip	Safety
10	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
11	Do your child always use a seat belt in the back seat (or use a booster seat if under 4'9")?	Yes	No	Skip	
12	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
13	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
14	Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
15	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	

Name: _____ **DOB:** _____

16	Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	Skip	
17	Has your child been hit or has your child hit someone in the past year?	No	Yes	Skip	
18	Has your child ever been bullied, felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
19	Does your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
20	Does your child often seem sad or depressed?	No	Yes	Skip	Mental Health
21	Does your child spend time with anyone who smokes?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
22	Has your child ever smoked cigarettes or chewed tobacco?	No	Yes	Skip	
23	Are you concerned your child may be using drugs or sniffing substances, such as glue, to get high?	No	Yes	Skip	
24	Are you concerned that your child may be drinking alcohol, such as beer, wine, wine coolers, or liquor?	No	Yes	Skip	
25	Does your child have friends or family members who have a problem with drugs or alcohol?	No	Yes	Skip	
26	Has your child started dating or "going out" with boyfriends or girlfriends?	No	Yes	Skip	Sexual Issues
27	Do you think your child might be sexually active?	No	Yes	Skip	
28	Do you have any other questions or concerns about your child's health or behavior?	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:

Pediatric ACEs and Related Life Events Screener (PEARLS)

CHILD - To be completed by: **Caregiver**

Patient Name: _____ **DOB:** _____

At any point in time since your child was born, has your child seen or been present when the following experiences happened? Please include past and present experiences.

Please note, some questions have more than one part separated by "OR." If any part of the question is answered "Yes," then the answer to the entire question is "Yes."

PART 1:	Please check "Yes" where apply. ☑
1. Has your child ever lived with a parent/caregiver who went to jail/prison?	☐
2. Do you think your child ever felt unsupported, unloved and/or unprotected?	☐
3. Has your child ever lived with a parent/caregiver who had mental health issues? *(for example, depression, schizophrenia, bipolar disorder, PTSD, or an anxiety disorder)*	☐
4. Has a parent/caregiver ever insulted, humiliated, or put down your child?	☐
5. Has the child's biological parent or any caregiver ever had, or currently has a problem with too much alcohol, street drugs or prescription medications use?	☐
6. Has your child ever lacked appropriate care by any caregiver? *(for example, not being protected from unsafe situations, or not cared for when sick or injured even when the resources were available)*	☐
7. Has your child ever seen or heard a parent/caregiver being screamed at, sworn at, insulted or humiliated by another adult? Or has your child ever seen or heard a parent/caregiver being slapped, kicked, punched beaten up or hurt with a weapon?	☐
8. Has any adult in the household often or very often pushed, grabbed, slapped or thrown something at your child? Or has any adult in the household ever hit your child so hard that your child had marks or was injured? Or has any adult in the household ever threatened your child or acted in a way that made your child afraid that they might be hurt?	☐
9. Has your child ever experienced sexual abuse? *(for example, anyone touched your child or asked your child to touch that person in a way that was unwanted, or made your child feel uncomfortable, or anyone ever attempted or actually had oral, anal, or vaginal sex with your child)*	☐
10. Have there ever been significant changes in the relationship status of the child's caregiver(s)? *(for example, a parent/caregiver got a divorce or separated, or a romantic partner moved in or out)*	☐

How many "Yes" did you answer in Part 1?: ☐

CENTER for YOUTH WELLNESS

UCSF Benioff Children's Hospital Oakland

Please continue to the other side for the rest of questionnaire →

Patient Name: _____ **DOB:** _____

PART 2:	Please check "Yes" where apply. ☑
1. Has your child ever seen, heard, or been a victim of violence in your neighborhood, community or school? *(for example, targeted bullying, assault or other violent actions, war or terrorism)*	☐
2. Has your child experienced discrimination? *(for example, being hassled or made to feel inferior or excluded because of their race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disabilities)*	☐
3. Has your child ever had problems with housing? *(for example, being homeless, not having a stable place to live, moved more than two times in a six-month period, faced eviction or foreclosure, or had to live with multiple families or family members)*	☐
4. Have you ever worried that your child did not have enough food to eat or that the food for your child would run out before you could buy more?	☐
5. Has your child ever lived with a parent/caregiver who had a serious physical illness or disability?	☐
6. Has your child ever been separated from their parent or caregiver due to foster care, or immigration?	☐
7. Has your child ever lived with a parent or caregiver who died?	☐

How many "Yes" did you answer in Part 2?: ☐

Today's Date: _____

Name of person completing form and relation to patient:

_____

Provider Signature: _____