Valentine Medical Clinic

8990 Garfield St Suite 6
Riverside, CA 92503
Phone (951)343-1616 - Fax (951)343-1666

Family Practice/Pediatrics

(Please Print) **Date**

PATIENT INFORMATION

Last Name **First Name** **Middle Initial /AKA**

Date of Birth **Social Security Number** **Gender** Male Female Transgender

Marital Status ☐ Single ☐ Married ☐ Life Partner ☐ Separated Divorced Widowed Other

Race **Language:** **Email Address**

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Cell Phone** **Other Phone** ☐ Work

Employment Status ☐ Employed Full-Time ☐ Employed Part Time ☐ Student ☐ Child ☐ Not Employed ☐ Homemaker ☐ Retired ☐ Disabled ☐ Active Duty Military ☐ Self Employed Other

RESPONSIBLE PARTY/GUARDIAN (GUARANTOR) INFORMATION

Relationship to Patient ☐ Self (If self, skip to Emergency / Next of Kin) ☐ Spouse ☐ Parent ☐ Other

Last Name **First Name** **Middle Initial**

Date of Birth **Social Security Number**

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Cell Phone** **Other Phone** ☐ Work

Employer **Employer Phone Number**

Employment Status ☐ Active-Duty Military ☐ Employed Full-Time ☐ Not Employed ☐ Student ☐ Child ☐ Employed Part-Time ☐ Retired ☐ Disabled ☐ Homemaker ☐ Self Employed ☐ Other

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name **First Name** **Relationship to Patient**

Address **Apt #** **City** **State** **Zip Code**

Home Phone **Cell Phone** **Other Phone** ☐ Work

LIST ANY ALLERGIES/PHARAMCY NAME/PHONE NO./MEDICATIONS

Allergies:

Preferred Pharmacy: **Phone Number** **Main Cross Streets**

Current Medications:

- **THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I ALSO AUTHORIZE VALENTINE OTUECHERE, M.D, MPH OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIM.**
- **I ALSO AUTHORIZE THE PHYSICIAN TO VIEW PRESCRIPTION HISTORY.**
- **I AUTHORIZE FOR MY PICTURE TO BE TAKEN FOR MY LIFE**

PATIENT/GUARDIAN
SIGNATURE____ DATE:_______________

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INFORMACION DEL PACIENTE

Apellido **Primer Nombre** **Inicial de Segundo Nombre**

Fecha de Nacimiento **No. de Seguro Social** **SEXO** ☐ Masculino ☐ Femenino ☐ Transgénero

Estado Civil ☐ Soltero ☐ Casado/a ☐ Viudo/a ☐ Divorciado/a ☐ Copañero de Vida ☐ Separado/a

Raza **Idioma:** **Correo Electronico:**

Direccion **No.de Apt #** **Cuidad** **Estado** **Codigo Postal**

Telefono de Casa **Telefono Celular** **Otro Telefono** ☐ Trabajo

Situación Laboral ☐ Empleado a tiempo completo ☐ Empleado a tiempo parcial ☐ Estudiante ☐ Niño/Menor de Edad ☐ No empleado ☐ Ama de casa ☐ Jubilado ☐ Discapacitado ☐ Militar en servicio activo ☐ Trabajador por cuenta propia ☐ Otro

INFORMACIÓN DE LA PARTE RESPONSABLE / TUTOR (GARANTE)

Relación con el Paciente ☐ Yo mismo (si es él mismo, pase a Emergencia / Pariente más cercano) ☐ Esposo/a ☐ Padre ☐ Otro

Apellido **Nombre** **Inicial del Segundo Nombre**

Fecha de Nacimiento **Número de Seguro Social**

Dirección **No. de Apt #** **Cuidad** **Estado** **Codigo Postal**

Teléfono de Casa **Teléfono Celular** **Otro Teléfono** ☐ Trabajo

Empleador **Teléfono del Empleador**

Situación Laboral ☐ Militar en servicio activo ☐ Empleado a tiempo completo ☐ No empleado ☐ Estudiante ☐ Niño/menor de edad ☐ Empleado a Tiempo Parcial ☐ Jubilado ☐ Discapacitado ☐ Ama de casa ☐ Trabajador por Cuenta Propia ☐ Otro

INFORMACIÓN DE CONTACTO DE EMERGENCIA / SIGUIENTE PARIENTE

Apellido **Primer Nombre** **Relación con el Paciente**

Direccion **No.de Apt #** **Cuidad** **Estado** **Codigo Postal**

Telefono de Casa **Telefono Celular** **Otro Telefono** ☐ Trabajo

INDIQUE CUALQUIER ALERGIA / NOMBRE DE FARMACIA / NÚMERO DE TELÉFONO / MEDICAMENTOS

Alergias:

Farmacia Preferida: **Número de Teléfono** **Calles Pricipales**

Medicamentos:

- LA INFORMACIÓN ANTERIOR ES VERDADERA A MI MEJOR CONOCIMIENTO. AUTORIZO QUE MIS BENEFICIOS DE SEGURO SE PAGAN DIRECTAMENTE AL MEDICO. ENTIENDO QUE SOY FINANCIERAMENTE RESPONSABLE DE CUALQUIER SALDO. TAMBIÉN AUTORIZO A VALENTINE OTUECHERE, M.D, MPH O COMPAÑÍA DE SEGUROS PARA DIVULGAR CUALQUIER INFORMACIÓN REQUERIDA PARA PROCESAR MI RECLAMO.
- TAMBIÉN AUTORIZO AL MÉDICO PARA VER EL HISTORIAL DE RECETAS.
- AUTORIZO QUE MI FOTO SE TOMARÁ DE MI VIDA

FIRMA DEL PACIENTE/PADRE/GUARDIAN____________________ FECHA: __________

ADULT HEALTH HISTORY

Name/Nombre	Age/Edad	D.O.B./Cuando Nacio	Date/Fecha

HISTORY OF PAST ILLNESS Have you had?/ENFERMEDADES PASADAS: (Ha tenido)

Measles/Sarampion..........No Yes/Si
Mumps/Paperas...............No Yes/Si
Chickenpox/Viruela..........No Yes/Si
Diabetes.......................No Yes/Si
Strokes/Embolio..............No Yes/Si

Rheumatic fever/Fiebre Reumatica..........No Yes/Si
Heart Disease/Enfermedad del Corazon.....No Yes/Si
Tuberculosis.......................................No Yes/Si
Venereal Disease/Enfermedad Veneria......No Yes/Si
Serious Disease/Enfermedad Graves.........No Yes/Si

Ever Hospitalized/Ha sido hospitalisado...No Yes/Si...Explain/Explicacion____________
Ever had surgery/Ha tenido operaciones.....No Yes/Si...Explain/Explicacion____________
Had broken bones/Ha tenido fracturas.......No Yes/Si...Explain/Explicacion____________
Head concussions or injuries/
Glopes o Heridas de cabeza.........No Yes/Si...Explain/Explicacion____________
Date of Last Tetanus Shot/La Fecha de su ultima immunizacion de Tetno____________
Date of Last PAP Smear/La Fecha de papanicolou exam de cancer____________
Date of Last Mammogram/Mammographia____________

FAMILY HISTORY/HISTORIA FAMILIAR:

Has anyone in your family ever had?/Ha habido en su familia?

Cancer	No	Yes/Si...Who/Quien?____________
Diabetes	No	Yes/Si...Who/Quien?____________
Tubercúlosis	No	Yes/Si...Who/Quien?____________
Heart trouble/Enfermedad del corazon	No	Yes/Si...Who/Quien?____________
High blood pressure/Presion alta	No	Yes/Si...Who/Quien?____________
Stroke/Embolio	No	Yes/Si...Who/Quien?____________
Convulsions/Epilepcia	No	Yes/Si...Who/Quien?____________
Suicide/Suicidio	No	Yes/Si...Who/Quien?____________

SOCIAL HISTORY/HISTORIA SOCIAL:

Single/Soltero ☐ Married/Casado ☐ Seperated/Separado ☐ Divorced/Divorciado ☐ Widowed/Viudo ☐
Alcoholic Beverages/Bebidas Alcolicas: Never/Nunca____________ How much/Cuanto____________
Tobacco or Cigarettes/Tobacco o Cigarillos: Never/Nuca____________ How much/Cuanto____________
Are you sexually active?/Esta sexualmente activa? Y ☐ N ☐
What is your job?/Cual es su trabajo?____________
Education Level/Nivel de Education:1☐2☐3 ☐4 ☐5☐6☐7☐8☐9☐10☐11☐12☐ College/Colegio Supenor: 1☐2☐3☐4☐
Ethnic Background/Nacionalidad ☐ American Indian ☐Asian ☐Filipino ☐ Pacific Islander ☐ Black ☐ Hispanic ☐ White

SYSTEMIC REVIEW GENERAL?REVISION DE SYSTEMAS:

Recent weight change/Reciente cambio de peso?.. No Yes/Si
Have you been in good health most of your life?/Ha tenido buena salud la mayor parte su vida?.... No Yes/Si

HAVE YOU EVER HAD PROBLEMS WITH?/ALGUNA VEZ HA TENIDO PROBLEMAS CON?

Skin/Piel...No Yes/Si....Explain/Explicacion____________
Head-Eyes-Ears-Nose-Throat/
Cabeza-Ojos-Oidos-Nanz-Garganta.......................No Yes/Si...Explain/Explicacion____________
Neck/Cuello..No Yes/Si...Explain/Explicacion____________
Lungs/Pulmones...No Yes/Si...Explain/Explicacion____________
Heart and Circulation/Corazon o Circulacion............No Yes/Si...Explain/Explicacion____________
Blood/Sangre...No Yes/Si...Explain/Explicacion____________
Emotions/Emociones..No Yes/Si...Explain/Explicacion____________
Nerves/Nervios...No Yes/Si...Explain/Explicacion____________
Muscles and Bones/Musculos o Huesos..................No Yes/Si...Explain/Explicacion____________
Stomach and Bowels/Estomago o Intestinos............No Yes/Si...Explain/Explicacion____________
Sex Organs/Organos Sexuales..............................No Yes/Si...Explain/Explicacion____________
Urinary/Unnanos...No Yes/Si...Explain/Explicacion____________
Any other/Cualquiera otro...................................No Yes/Si...Explain/Explicacion____________

ALLERGIES OR REACTIONS TO FOOD /MEDICATION/LATEX
ALERGIAS O REACCIONES A ALIMENTOS / MEDICINAS/LATEX____________

PATIENT SIGNATURE/FIRMA____________ DATE/FECHA____________

DOCTOR SIGNATURE ____________ DATE/FECHA____________

PATIENTS RIGHTS AND RESPONSIBILITIES

To comply with new federal regulations (HIPAA), this office has established procedures to make your identity and medical records more secure. Our only use of your personal information is for billing purposes and for proper medical treatment. We must have on record, a signed acknowledgement, that you have read your rights and responsibilities as patients and that you understand them. Please contact the office staff if you have any questions.

PATIENTS RIGHTS

- To receive service within a reasonable period of time.
- To receive medically necessary services.
- To be treated with respect and courtesy.
- To receive all available information about your care and treatment, including risks and options.
- To have your medical coverage explained to you.
- To have all medical and personal records treated as confidential.
- To participate in treatment decisions.
- To refuse treatment.
- To receive impartial access to treatment.
- To receive a second opinion regarding any treatment plan.
- To review or to receive a copy of your medical record subject to legal restrictions and reasonable copying charges.
- To request review of your medical record by the physician, and to request corrections if necessary.
- To be given information on how to file a complaint/grievance.
- To formulate an advance directive if you have a life threatening illness or injury.
- To provide, or have provided for you, an interpreter in your primary language.

PATIENTS RESPONSIBILITIES

- Having appropriate identification, insurance membership cards, coverage stickers, etc, at the time of the appointment.
- Keeping appointments or contacting this office in advance to cancel an appointment.
- Fulfilling financial obligations at the time of service such as deductible or co-pay fees.
- Providing complete and accurate information.
- Following the health plan you and the physician agree on.
- Being considerate of others.
- Providing legal documentation of guardianship of a minor being treated.
- Providing a list of persons who may receive medical information about you, on your behalf, in an emergency.

Please sign and return this form to the front desk

PATIENT'S NAME ______________________ DATE __________

REORDER FROM INLAND EMPIRE MEDICAL OFFICE SYSTEMS (951) 354-6270

ILLEGAL

DERECHOS Y RESPONSABILIDADES DE LOS PACIENTES

Para cumplir con las nuevas leyes Federales (HIPAA), esta oficina ha establecido procedimientos para hacer que su identidad y su historia medica esten mas seguros. El unico uso que le damos a su información es para propositos de cobrar sus costos medicos y el adecuado tratamiento medico. Debemos tener en su historial medico una declaration de que usted a leido sus derechos y responsabilidades y que usted ha entendido perfectamente. Por favor llame a nuestra oficina si tiene alguna pregunta.

DERECHOS DE LOS PACIENTES

- Recibir atencion medica dentro de un tiempo rasonable.
- Recibir servicios medicos necesarios.
- Ser tratado con respeto y cortesia.
- Recibir toda la información necesaria respecto a su cuidado medico, tratamiento, incluyendo los riesgos y opciones.
- Tener información acerca de su cobertura medica
- Tratar su historial medico y personal de manera confidencial.
- Tener derecho a participar en las decisiones de su tratamiento medico.
- Tener derecho a reusar el tratamiento
- Recibir acceso imparcial al tratamiento
- Recibir una segunda opinion segun el plan de tratamiento
- Revisar o recibir copias de su historia medica sujeto a las restricciones legales y razonables costo por las copias.
- Pedir revision de su historial medico por el medico y pedir correciones si es necesario
- Recibir información sobre como presentar una queja
- Formular un «advance directive» en el caso de estar con una enfermedad grave o lesion severa
- A que se le provea o a que traiga con usted un interprete en su propio idioma.

RESPONSABILIDADES

- Tener apropiada identificacion, su tarjeta de seguro medico (aseguranza), cobertura del plan etc. al momento de su cita medica.
- Cumplir su cita medica o llamar a la oficina con tiempo suficiente para cancelar su cita.
- Pagar sus obligaciones financieras al momento en que se le presta el servicio, como el costo del deductible o el co-pago.
- Proveer información completa y verdadera.
- Cumplir con el plan de tratamiento que usted acepto y que le fue ordenado por su medico.
- Ser considerado con las demas personas
- Proveer información de los documentos legales si usted es el guardian de un menor que esta siendo tratado.
- Proveer una lista de personas que deben recibir información medica acerca suyo on en su nombre en caso de una emergencia.

Por favor lea y firme esta forma y entregala en la recepcion de la oficina

NOMBRE DE PACIENTE ____________________ FECHA ________

COMMUNICATION CONSENT AGREEMENT

I UNDERSTANT THAT UNDER FEDERAL LAW (HIPAA), THIS MEDICAL OFFICE MAY ***NOT*** RELEASE ANY MEDICAL INFORMATION TO ANY INDIVIDUAL, WITHOUT MY EXPRESS WRITTEN PERMISSION. LAW ENFORCEMENT AND COURT ORDER ARE TWO EXCEPTIONS TO THIS REQUIREMENT. I, THEREFORE, ***GIVE*** PERMISSION TO THIS OFFICE TO RELEASE MEDICAL INFORMATION ON MY BEHALF, TO THE FOLLOWING PERSON(S):

Name: ______________________________ Relationship: ______________

Address: ____

Phone #: ____________________ Age: _____ Birthday: _______________

Drivers License #: __________________ Social Security #: _______________

Other Forms of Identification: ______________________________________

Name: ______________________________ Relationship: ______________

Address: ____

Phone #: ____________________ Age: _____ Birthday: _______________

Drivers License #: __________________ Social Security #: _______________

Other Forms of Identification: ______________________________________

Authorized Methods of Communication (check all that apply)			
☐ Home Telephone	☐ Work Telephone	☐ Written Correspondence	☐ Other
Number	Number	Mail/Delivery Service	
☐ Leave call back number only: Do not leave message	☐ Leave call back number only: Do not leave message	☐ Fax #	
☐ Okay to leave detailed message with person	☐ Okay to leave detailed message with person		
☐ Okay to leave detailed message on answering machine	☐ Okay to leave detailed message on personal voice mail		

Patient Signature:________________________________ **Date:** ________________

ADVANCE DIRECTIVE QUESTIONNAIRE

1) Have you formulated an Advance Directive? YES ________ NO ________

2) If you have formulated an Advance Directive, please check the type that you have.

   a) Durable Power of Attorney for Health Care: ________________

   b) California Natural Death Act: ________________

   c) Living Health Care Will: ________________

   d) Other: ________________

3) If you have formulated an Advance Directive, you hereby agree to furnish ________ ________________ with a copy within ________ days.

4) If you change, amend, alter or cancel your Advance Directive, you hereby agree to notify ________________ and provide ________________ with a copy as soon as possible so that your physician will be able to comply with your wishes.

5) Expiration date of Advance Directive, if any ________________

   (If the Advance Directive was formulated before 1991, it is "good" for only seven years. Advance Directives formulated after 1991, are "good" indefinitely; unless you change/amend/cancel the Advance Directive.)

6) I would like more information about Advance Directives. Yes ______ No ______

Patient Signature: ________________ Date: ________

Patient's name: ________________

ESPAÑOL AL REVERSO→

ADVANSADO QUESTIONARIO DIRECTIVO

1. Ha Usted formulado un Advansado Directivo Si__________ No___________

2. Si, Usted ha formulado un Advansado Directivo, favor de chequear el tipo.
   a. Durable poder de abogado para su salud:____________________________________

   b. Acto de California de muerte natural.______________________________________

   c. Testamento de cuidados de salud mientras vive.______________________________

   d. Otro ____

3. Si, usted ha formulado un advansado directivo, usted de accuerdo de prover ha_________________ con una copia en ________________________dias.

4. Si usted ha hacho cambios, agregaciones, altera o cancela el advansado directivo, Usted esta de accuerdo de notificar ha__________________________y proverle______________con una copia lo mas pronto possible ha su doctor para Que cumpla con sus deseos.

5. Fecha de expiracion, si la tiene, ________________________(Si el Advansado Directivo fue, fumulado antes de 1991, solamente es Buena para siete anos. Advansado Directivo furmulado despues del 1991, is indefinitivamente Buena: pero no si ha hecho cambios, agregaciones, o cancelado el Advansado Directivo.)

6. Me gustaria mas Informacio sobre el Advansado Directivo. Si____________No__________

Firma de Paciente____Fecha___________

Nombre de Pacient____

Tuberculosis Evaluation Questionnaire

Cuestionario Evaluatorio Sobre Tuberculosis

***You (your child) may be at increased risk for TB if you answer YES to any of the following questions.**
****Sus hijos pueden tener un riesgo muy alto de poder contraer "TB" si contesta en informa affirmative a cualquiera de las siguientas preguntas.***

Name:________________________________ **Medical Record#:**__________________

Age:________________ **DOB:**________________ **DOS:**____________________

1. **Have you (has your child) ever had a positive tuberculosis (TB) skin test? If so, what date?**
   ¿Acaso ested (o su hijo/a) recibido a un resultado positive del examen de tuberculosis?
   YES / SI ☐ Date/Fecha:________ NO ☐

2. **Do you have a family member or close contact with a history of confirmed or suspected TB?**
   ¿Existe algun contacto cercano o algun mimbro de la familia que haya sido declarado enfermo de TB o que se sospeche tener esta enferedad?
   YES / SI ☐ NO ☐

3. **Were you (was your child) born in or travel to high TB prevalence countries?** (Africa, Asia, or Latin America)
   ¿Nacio ested (o su hijo/a) fuera de los Estados Unidos o visita lugares donde hay tuberculosis? (Africa, Asia, o Latino America)
   YES / SI ☐ NO ☐

4. **Do you have any family members or frequent visitors who are from Africa, Asia, or Latin America?**
   ¿Tiene usted familiars provenientes de Africa, Asia, o Latino America Viviendo en su hogar?
   YES / SI ☐ NO ☐

5. **Do you (does your child) have a history of confirmed or suspected HIV infection or other problems with their immune system?**
   ¿Acaso ested (su hijo/a) haya sido diagnosticado(a) con algun tipo de infeccion como el sida o con problemas con su sistema immuno?
   YES / SI ☐ NO ☐

6. **Do you (does your child) live with any individual who is HIV positive?**
   ¿Acaso ested (o su hijo/a) haya sido declarado positive con el examen del sida?
   YES / SI ☐ NO ☐

7. **Do you (does your child) live in an "out of home" placement facility?**
   ¿Acuso ested (su hijo/a) se encuentra viviendo temporalmente en un hogar o local sostenido por el gobierno o asistenoia social?
   YES / SI ☐ NO ☐

8. **Have you been, or do you (does your child) live with any individual who has been incarcerated in the last 5 years?**
   ¿Acaso ested (o su hijo/a) vive con adultos que hayan estado presos or cualquier motivo en los ultimos 5 anos?
   YES / SI ☐ NO ☐

9. Do you (does your child) live among, or are you (is he/she) frequently exposed to individuals who are homeless, migrant farm workers, users of street drugs, or residents in a nursing home?
¿Acaso ested (o su hijo/a) vive o se asocial frecuentemente con personas que viven en las calles, que sean trabajadores temporales del campo, utilicen drogas ilicitas inyectables o que residan en asilos o en hospitals de convalescencia?
YES /SI ☐ NO ☐

10. Do you (does your child) consume alcoholic beverages?
¿Usted (su hijo/a) consume alchol?
YES / SI ☐ how much / cuanto______________ NO ☐

** A person who is at increased risk for TB should have a yearly TB test.*
(All children are tested routinely for TB at 4-5 years, 13-16 years, regardless of risk)

**Cualquir persona que tiene un alto riesgo de contraer TB debe hacerse el examen de la tuberculosis cada ano. (se les examina a los 4 y 5 anos y do los 13 a 16 anos)*

PATIENT CONSENT TO TREATMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ______________________________

Signature: ______________________________

Relationship to Patient: ______________________________

Date: ______________________

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8990 Garfield St Suite 6
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PATIENT AUTHORIZATION TO RELEASE INFORMATION

PATIENT'S NAME:________________________ **DATE OF BIRTH**_________

(IN COMPLIANCE WITH THE FEDERAL"HIPPA" GUIDELINES)

How we may use and disclose your health information.

Your protect health information will be used by our office or disclosed to other for the purpose of **treatment, obtaining payment, or supporting the day-to-day health care operations of the practice**.

The notice of privacy practices.

Our office is required to provide to you a noticed that describes how information about you may be used and diclosed. Additionally, we must provide you information on how you may get access to information. These policies and practices are defined in the "Notice of Privacy Practices of this office" paper provided to you. Please review it carefully.

You may placed restrictions on the use or discloure of your health information.

You may request a restriction on the use or disclosure of our protected information. However, our office may or may not agree to your request to restrict the use to activate this request. please consult with a practice representative or the Privacy official if you like additional information or clarification. It is a violation of the federal privacy standards if our office agrees and fails to comply with your request. The restrictions requested will not affeect use and disclosure of your information prior to the date of your request.If you still have questions after reviewing the Notice of Privacy, please consult with a Practice Representative or the Privacy Official at the location and contact information listed on the back of the papper.

You May revoke this consent at anytime.

You may revoke this consent at anytime; however our office requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect the use and disclousure prior to the date of your request.

Changes to privacy practices.

Our office reserves the right to change or modified the privacy practictices outlined in the noticed of Privacy paper. You will be notified of any change of privacy practices at your next appointment.

Signature.

I have reviewed this consent form, received the paper entitled **"Notice Of Privacy Practices of this Office"** and give my permission to **Valentine Medical Clinic** and Associates to use and disclose my health information in accordance with this consent and the notice provided.

NOTICE TO CONSUMERS Medical doctor is licensed and regulated by the Medical Board of California (800)633-2322 www.mbc.ca.gov

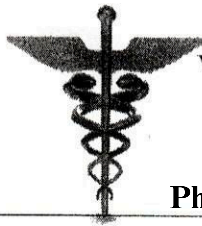
Patient's Name____
PLEASE PRINT

Signature:_______________________________ Date:____________________

Patient's Represenative______________________________________
PLEASE PRINT

Relationship to Patient:____________________________________

Signature:_______________________________ Date:____________________



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Phone (951)343-1616 - Fax (951)343-1666

Family Practice / Pediatrics

☐ **STAT** ☐ **ROUTINE**

AUTHORIZATION TO RECEIVE OR RELEASE MEDICAL INFORMATION

THIS AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION IS BEING REQUESTED OF YOU TO COMPLY WITH THE TERMS OF THE CONFIDENTIALITY OF MEDICAL INFORMATION ACT 1981, SECTION 58 SEQ.OF THE CALIFORNIA CIVIL CODE

Patient's Last Name (Please Print)	First		Date of Birth
Patient Address	**City**	**State**	**Zip Code**
Give Other Name Patient Received Treatment Under	**Phone No.**		**Message Phone No.**
S.S.N / **Entity/Group**	**CHB**	**Medical Record Number**	

FROM		TO	
Name of Physician/Health Care Provider/Other		**Name of Physician/Health Care Provider/Other**	
		VALENTINE MEDICAL CLINIC	
Address	**City/State/Zip Code**	**Address**	**City/State/Zip Code**
		8990 Garfield St Suite 6 Riverside, 92503	
Fax Number	**Phone Number**	**Fax Number**	**Phone Number**
		(951)343-1616	(951)343-1666

☐ All Available Records

☐ Only Information listed below/Following Dates:

under some circumstances information in a record that mentions HIV, Drug Use, Alcohol use or Mental conditions, will require an additional authorization

☑ **Primary Care Physician/Medical Care**

☐ Billing

☐ Outside Medical Review

☐ Other ____________________

Duration

This authorization shall become effective immediately for 90 days

Restrictions

I understand that the requester may not further use disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I also understand that pertaining parties have the right to receive a copy of this authorization.

______________________________ ______________

PATIENT/GUARDIAN/AUTHORIZED REPRESENTATIVE DATE

____

WITNESS

Valentine Medical Clinic
Patient Dismissal, Late Cancel and No-Show Policies

Patient Dismissal Policy

Purpose: To define the situations under which a provider or this practice may and may not elect to dismiss a patient from receiving care within the clinic.

Valentine Medical Clinic Consists of: Physicians, Practicing Providers, Auxiliary Providers, all corresponding Staff including but not limited to Practicing Students, Supporting staff, Guests

Definitions:

No-Show: An appointment missed without notifying the department in advance or patients who arrive more than 15 minutes late for check-in and cannot be seen that day will be considered a no-show.

Established Patient: An established patient is one who has received professional services from a physician/qualified health care professional or another physician/other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

Chronic No-Show Established Patient: A patient will be considered a chronic no-show if the patient has logged three or more no-shows in a rolling 12-month period beginning with the first no-show event. The no-shows do not need to be consecutive.

New Patient: A new patient is one who has not received any professional services from a physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

Chronic No-Show New Patient: A patient will be considered a chronic no-show new patient if the patient has logged two or more no-shows with that practice notwithstanding time frame.

Violent patient: A patient will be considered violent if they exhibit any hostile action of a hurtful nature, or any action that displays an intention to physically harm any employed or contracted person or other patient of the practice.

Harassment: Harassment is any verbal or physical conduct that shows hostility toward an individual based on their race, color, religion, gender, sexual orientation, gender identity, marital status, age, physical or mental disability, or any other class protected by federal, state, or local law.

Policy:

It is the policy of Valentine Medical Clinic that its providers are not required to continue treating a patient who is uncooperative, violent and/or who harasses any VMC staff.

Patients may be considered for dismissal from the department for exhibiting any of the following behaviors:

-**Chronically missing appointments** (see the VMC Appointment No-Show and Late Cancel Policy for further detail);

-**Refusing to cooperate** with the physician, advanced practice provider, or any employee of the practice; As patients possess autonomy and self-determination, which includes the right to accept or refuse medical treatment, a patient has the right to decide whether or not to proceed with a specific course of treatment. **However**, if the patient has repeated noncompliance or the provider is of the opinion the patient-provider relationship has been irrevocably damaged due to the patient's refusal to cooperate, the provider does have the right to end the patient-provider relationship.

-**Threatening** or filing of lawsuits against individuals and/or the clinic;

-**Displaying a threatening** or hostile attitude/behavior/action that makes any staff member or another patient feel unsafe or harmed; Demonstrating violent or abusive behavior;

-**Violating** the Controlled Substance Agreement;

-**Loss** of provider/patient therapeutic/professional relationship, including but not limited to, treatment, nonadherence follow-up, noncompliance, unethical/dishonest/fraudulent behavior and verbal/social/print media slander.

In addition to dismissal from the practice, violent or abusive patients/guests, or patients/guests engaging in harassment of any kind will be managed accordingly, up to and including charges being filed with applicable law enforcement agencies.

A patient's return to services within the clinic will be at provider/clinic's discretion.

A patient will have 30 days from letter print date to transfer to a new provider. During that time, they may receive acute care and discretionary medication refills.

<u>Patients may not be considered for dismissal for either of the following listed reasons:</u>

Financial reasons, such as the inability to pay for services rendered;
Race, ethnicity, sexual orientation, gender identity, sex, citizenship status, pregnancy, disability, military status, religion;
Patient's age may require a transfer of care to an appropriate provider.

Late Cancel & No Show Policy

Purpose: To define the policy for late cancellations and no shows of patient appointments across Valentine Medical Clinic

Definitions:

Valentine Medical Clinic Consists of: Practicing Physicians, Auxiliary Providers, all corresponding Staff including but not limited to Practicing Students, Supporting staff, Guests

Late Cancel: An appointment cancelled within 24 hours of the appointment start time.

No-Show: An appointment missed without notifying the clinic in advance or patients who arrive more than 15 minutes late for check-in and cannot be seen that day will be considered a no-show.

Established Patient: An established patient is one who has received professional services from a physician/qualified health care professional or another physician/other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

Chronic No-Show Established Patient: A patient will be considered a chronic no-show if the patient has logged three or more no-shows in a rolling 12-month period beginning with the first no-show event. The no-shows do not need to be consecutive.

New Patient: A new patient is one who has not received any professional services from a physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

Chronic No-Show New Patient: A patient will be considered a chronic no-show new patient if the patient has logged two or more no-shows with that practice notwithstanding time frame.

Policy:

No Show

Any appointment that qualifies as a no-show by the above definition will be marked either manually or by the system as no-show in the final appointment status of the scheduling system.
No-shows for established patients will be tracked over a rolling 12-month period, beginning with the first no-show event.
No-Shows for new patients will be tracked.
Chronic no-show patients may be subject to dismissal by the practice.
Please refer to the Valentine Medical Clinic Dismissal Policy for appropriateness and procedures.
It is at the discretion of the provider/managing staff to accept or not accept patients that have been dismissed by other similar practices as new patients.
Please refer to the Valentine Medical Clinic Dismissal Policy for appropriateness and procedures.

Late Cancel

Any appointment cancelled within 24 hours of the appointment start time will be considered a Late Cancellation and marked as "Cancelled" in the final appointment status of the scheduling system.
Office staff will manually mark an appointment as Cancelled and may add a Cancellation Reason.
Patients cancelling their appointments via HEALOW will follow the definitions for Late Cancel and No Show outlined in this policy.

By Signing below, entering the premises, and/or receive treatment at Valentine Medical Clinic it is understood, acknowledged and adhere to the above.

____
Date

______________________ Patient Name

______________________ Patient Signature

______________________ Patient Guardian/Responsible Party Name

______________________ Patient Guardian/Responsible Party Signature

Valentine Medical Clinic

Polízas de baja de pacientes, cancelación tardía e inasistencia

Políza de baja de Pacientes

Propósito: Definir las situaciones en las que un proveedor o esta clínica puede o no optar por despedir a un paciente de recibir atención en la clínica.

Valentine Medical Clinic está compuesta por: Medicos, Médicos Practicantes, Provedores Auxiliares, todo el personal correspondiente, incluyendo, entre otros, Estudiantes en practica/entrenamiento, Personal de apoyo y Visitantes.

Definiciones:

Incomparecencia: Se considerará incomparecencia la ausencia a una cita sin notificar al departamento con anticipación, o la llegada con más de 15 minutos de retraso y la imposibilidad de ser atendido ese día.

Paciente establecido: Se considera incomparecencia a un paciente que ha recibido servicios profesionales de un médico/profesional de la salud calificado u otro médico/profesional de la salud calificado de la misma especialidad y subespecialidad, perteneciente al mismo grupo de práctica, en los últimos tres años.

Paciente establecido con incomparecencia crónica: Se considerará incomparecencia crónica a un paciente que haya registrado tres o más incomparecencias en un período consecutivo de 12 meses, a partir de la primera incomparecencia. Las inasistencias no tienen por qué ser consecutivas.

Paciente nuevo: Un paciente nuevo es aquel que no ha recibido servicios profesionales de un médico/profesional de la salud calificado, ni de otro médico/profesional de la salud calificado de la misma especialidad o subespecialidad que pertenezca al mismo grupo de práctica, en los últimos tres años.

Paciente nuevo con inasistencia crónica: Se considerará paciente nuevo con inasistencia crónica si ha registrado dos o más inasistencias en la clínica, independientemente del período de tiempo.

Paciente violento: Se considerará violento si exhibe cualquier acción hostil de naturaleza dañina o cualquier acción que muestre la intención de dañar físicamente a cualquier empleado o empleado contratado, o a otro paciente de la clínica.

Acoso: El acoso es cualquier conducta verbal o física que muestre hostilidad hacia una persona por su raza, color, religión, género, orientación sexual, identidad de género, estado civil, edad, discapacidad física o mental, o cualquier otra condición protegida por las leyes federales, estatales o locales.

Políza:

Valentine Medical Clinic tiene como políza que sus profesionales no están obligados a continuar atendiendo a un paciente que no coopere, sea violento o que acose al personal de la Clínica. Se puede considerar la baja del departamento por presentar cualquiera de los siguientes comportamientos:

-**Falta crónica de citas** (consulte la Política de inasistencia y cancelación tardía de citas de VMC para obtener más detalles);

-Negarse a cooperar con el médico, el profesional de la salud o cualquier empleado de la clínica. Dado que los pacientes poseen autonomía y autodeterminación, lo que incluye el derecho a aceptar o rechazar un tratamiento médico, tienen derecho a decidir si desean o no continuar con un tratamiento específico. Sin embargo, si el paciente presenta incumplimientos reiterados o el profesional considera que la relación entre ambos se ha dañado irrevocablemente debido a su negativa a cooperar, el profesional tiene derecho a terminar dicha relación.

-Amenazar o presentar demandas contra personas o la clínica.

-Mostrar una actitud, comportamiento o acción amenazante u hostil que haga que cualquier miembro del personal o paciente se sienta inseguro o perjudicado. Demostrar un comportamiento violento o abusivo.

-Incumplir el Acuerdo sobre Sustancias Controladas.

-Pérdida de la relación terapéutica/profesional entre el proveedor y el paciente, incluyendo, entre otros, el tratamiento, el seguimiento de la falta de adherencia, el incumplimiento, el comportamiento poco ético, deshonesto o fraudulento y la difamación verbal, social o en medios impresos.

Además del despido de la clínica, los pacientes/clientes violentos o abusivos, o los pacientes/clientes que participen en cualquier tipo de acoso, serán tratados como corresponde, incluyendo la presentación de cargos ante las autoridades competentes.

El regreso del paciente a los servicios en la clínica quedará a discreción del proveedor/clínica.

El paciente tendrá 30 días a partir de la fecha de impresión de la carta para transferirse a un nuevo proveedor. Durante ese tiempo, podrá recibir atención aguda y resurtidos de medicamentos discrecionales.

No se podrá considerar la baja de los pacientes por ninguna de las siguientes razones:

Motivos económicos, como la incapacidad de pagar los servicios prestados;

Raza, etnia, orientación sexual, identidad de género, sexo, ciudadanía, embarazo, discapacidad, servicio militar, religión;

La edad del paciente podría requerir la transferencia de la atención a un proveedor adecuado.

Propósito: Definir la política de cancelaciones tardías e inasistencias a citas de pacientes en la Clínica Médica Valentine.

Definiciones:

Valentine Medical Clinicestá compuesta por: Médicos en ejercicio, Auxiliares de enfermería, todo el personal correspondiente, incluyendo, entre otros, Estudiantes en ejercicio, Personal de apoyo y Visitantes.

Cancelación tardía: Una cita cancelada dentro de las 24 horas previas a la hora de inicio.

Inasistencia: Una cita perdida sin notificar a la clínica con anticipación, o pacientes que llegan con más de 15 minutos de retraso al registro y no pueden ser atendidos ese día, se considerará inasistencia.

Paciente Establecido: Un paciente establecido es aquel que ha recibido servicios profesionales de un médico/profesional de la salud calificado u otro médico/profesional de la salud calificado de la misma especialidad y subespecialidad, perteneciente al mismo grupo de práctica, en los últimos tres años.

Paciente Establecido con Inasistencia Crónica: Se considerará que un paciente ha inasistido crónicamente si ha registrado tres o más inasistencias en un período consecutivo de 12 meses, a partir de la primera. No es necesario que las inasistencias sean consecutivas.

Paciente nuevo: Se considera paciente nuevo a aquel que no ha recibido servicios profesionales de un médico/profesional de la salud calificado, ni de otro médico/profesional de la salud calificado de la misma especialidad o subespecialidad que pertenezca al mismo grupo de práctica, en los últimos tres años.

Paciente nuevo con inasistencia crónica: Se considerará paciente nuevo con inasistencia crónica si ha registrado dos o más inasistencias en esa práctica, independientemente del período de tiempo.

Políza:

Inasistencia

Toda cita que se considere inasistencia según la definición anterior se marcará manualmente o por el sistema como inasistencia en el estado final de la cita del sistema de programación.

Las inasistencias de pacientes registrados se registrarán durante un período consecutivo de 12 meses, comenzando con la primera inasistencia.

Las inasistencias de pacientes nuevos también se registrarán.

Los pacientes que no se presentan regularmente pueden ser dados de baja por la clínica.

Consulte la Política de Bajas de Valentine Medical Clinicpara conocer los procedimientos y la pertinencia de la misma.

Queda a discreción del proveedor/personal administrativo aceptar o no a pacientes que hayan sido dados de baja por otras clínicas similares como nuevos pacientes.

Consulte la Política de Bajas de Valentine Medical Clinicpara conocer los procedimientos y la pertinencia de la misma.

Cancelación tardía

Cualquier cita cancelada dentro de las 24 horas previas a la hora de inicio se considerará una cancelación tardía y se marcará como "Cancelada" en el estado final de la cita del sistema de programación.

El personal de la oficina marcará manualmente la cita como cancelada y podrá agregar un motivo de cancelación.

Los pacientes que cancelen sus citas a través de HEALOW deberán seguir las definiciones de cancelación tardía e inasistencia descritas en esta política.

Al firmar a continuación, ingresar a las instalaciones o recibir tratamiento en la Clínica Médica Valentine, se entiende, reconoce y cumple con lo anterior.

____

Fecha

________________________	________________________
Nombre del Paciente	Firma del Paciente
________________________	________________________
Nombre del guardian/(p)(m)adre/responsable del paciente	Firma del guardian/(p)(m)adre/responsable del paciente

VALENTINE MEDICAL CLINIC
8990 Garfield St Suite 6
Riverside, CA 92503
Phone (951)343-1616 - Fax (951)343-1666

NOTICE OF PRIVACY PRACTICE OF THIS OFFICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DEISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of ____________________, 20___ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775