Valentine Medical Clinic *[PEDIATRIC]*

16070 Tuscola Rd Suite 101
Apple Valley, CA 92307
Phone (760)267-9931 - Fax (760)267-9933

(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

PARENT/GUARDIAN 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 CONTACT INFORMATION/MUST BE PARENT OR GUARDIAN

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

PARENT/GUARDIAN SIGNATURE______________________________ DATE:____________

CHILD HEALTH HISTORY

HISTORY OF PREGNANCY WITH THIS CHILD:

During which month of pregnancy did you first see the doctor?______Month Where was baby born?______________________

How long was your pregnancy?______________________Months If baby was born at home, were blood tests for newborn screening done? ☐YES ☐NO

Did you have any illness or problem? (Including sexually transmitted or other communicable diseases)	YES	NO	Did you use any non-prescribed drug? (tobacco, alcohol, "Street drugs", over-the-counter or home remedies)	YES	NO
Did you take any medications prescribed by your doctor?	YES	NO	Did the baby go home with you from the hospital	YES	NO
Did you have a difficult/abnormal delivery/C-section?	YES	NO	Was more than one baby born?	YES	NO
Did the baby have any problems during the 1 st week of life?	YES	NO	Did baby receive any shots for Hepatitis B?	YES	NO

CHILD'S HISTORY: ☐MALE ☐FEMALE Is this child adopted? ☐YES ☐NO Birth Weight:________pounds ______ounces Length:______inches

Has your child ever had:

Measles, Chickenpox, Mumps, Rubella	YES	NO	Vomiting after eating, refusal to eat	YES	NO
Tuberculosis or positive TB test	YES	NO	Muscle, joint or bone problems	YES	NO
Tonsillitis/Sore Throat	YES	NO	Skin problems	YES	NO
Problems with eyes or vision	YES	NO	Headaches or dizziness	YES	NO
Problems with ears or hearing	YES	NO	Convulsions, seizures, epilepsy	YES	NO
Difficulty breathing/snoring at night	YES	NO	Diabetes	YES	NO
Heart problems	YES	NO	Thyroid problems	YES	NO
Asthma, bronchitis, or pneumonia	YES	NO	Allergies	YES	NO
Anemia, bleeding problems, blood transfusions	YES	NO	Problems with development or school performance	YES	NO
Stomachaches	YES	NO	Serious illness or accident	YES	NO
Diarrhea, soiling self with stool	YES	NO	Surgery or hospitalization	YES	NO
Bladder or Kidney Problems, Wetting self or bed	YES	NO	(Girls) Has she started her period?	YES	NO
Constipation	YES	NO	(Girls) Are there problems with her period?	YES	NO

FAMILY HISTORY: Does mother (M), father(F), brother(B), sister(S), aunt(A), uncle (U), or grandparent (GP) have:

			Which Family Member?				Which Family Member?
YES	NO	Diabetes		YES	NO	High blood pressure	
YES	NO	Epilepsy or convulsions		YES	NO	Bleeding disorder	
YES	NO	Mental retardation		YES	NO	Tuberculosis	
YES	NO	Heart disease		YES	NO	Allergy	
YES	NO	Cancer		YES	NO	Lung or breathing problems	
YES	NO	Kidney or urinary disease		YES	NO	Eye disorder	
YES	NO	Bone or joint problems		YES	NO	Ear disorder	

PARENT INFORMATION:

	Mother:	Father:
Age:	____________	____________
Height:	____________	____________
Occupation:	____________	____________

HOUSEHOLD INFORMATION: Number of people in home:____________

Are both parents living in the home? ☐Yes ☐No

Does anyone in the home smoke, or use drugs or alcohol? ☐Yes ☐No

Language spoke in the home:

Do you live in a: ☐House ☐Apartment ☐Mobile Home ☐Shelter ☐Homeless

Patient Identification:

Signature:______________________**Date:**____________

Relationship to Child:______________________

Reviewer's Signature:______________________**Date:**____________

Revised Date April 2010

What do you eat?

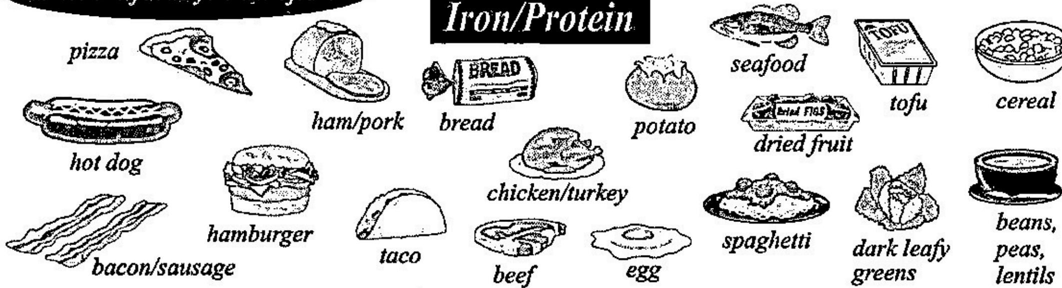
What did you eat yesterday? List everything you ate and drank. How much? What time?

Time	*Amount*	*Food or Drink*
10:00 a.m.	*½ cup*	*Carrots*

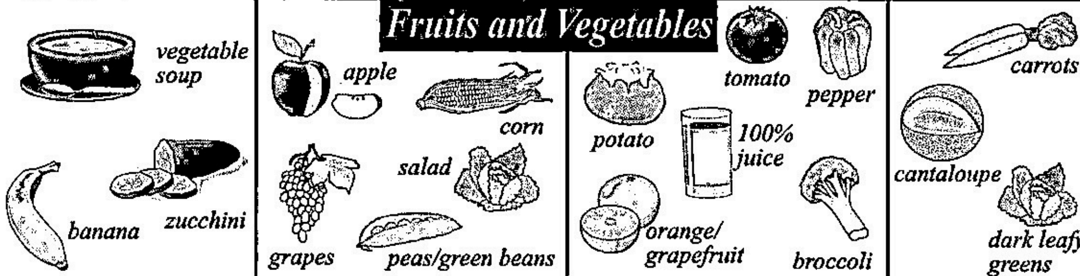
Was yesterday a typical day? _____Yes _____No

Circle the foods you eat often.

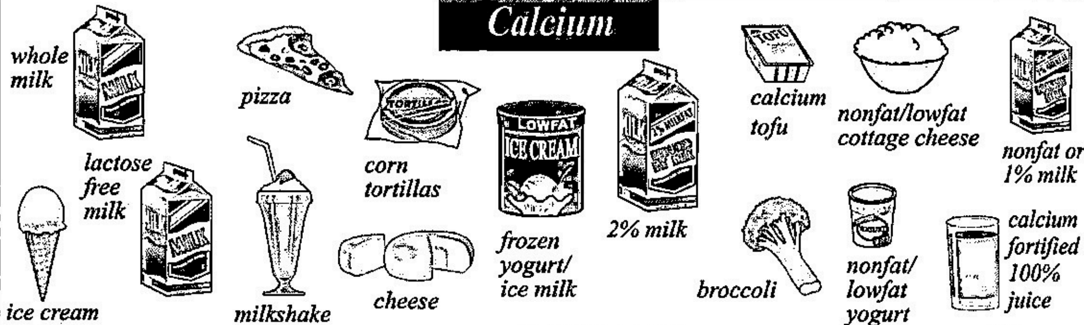
Iron/Protein



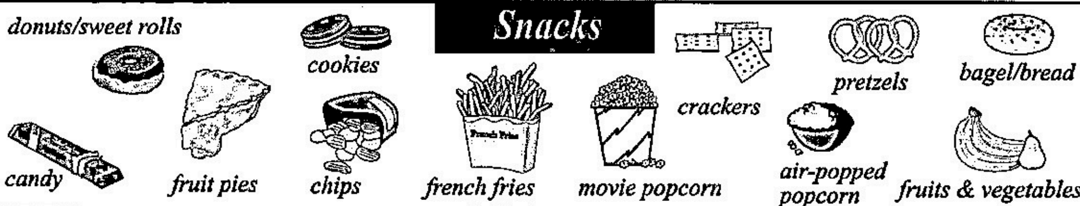
Fruits and Vegetables



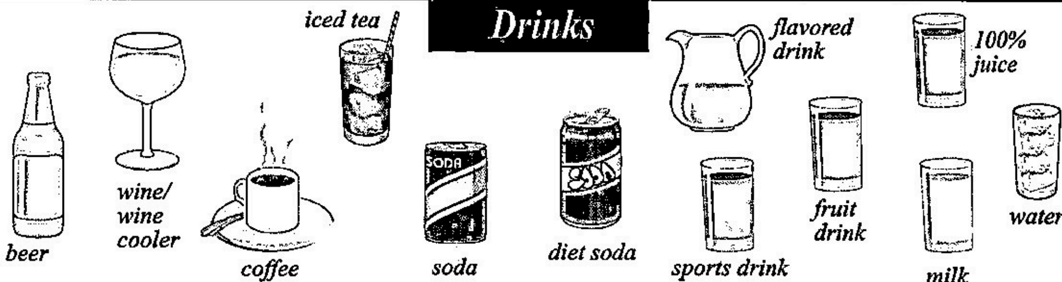
Calcium



Snacks



Drinks



For office use only

(Check (✓) topics discussed)

- ☐ Continue eating healthy
- ☐ ↑ regular meals/snacks
- ☐ Encourage breakfast
- ☐ Inadequate food supply
- ☐ Encourage lower fat
- ☐ Encourage lower sugar
- ☐ Weight management
- ☐ Disordered eating
- ☐ Other__________

Iron/Protein

- ☐ 2 - 3 servings daily
- ☐ ↑ high iron foods
- ☐ ↑ alternate protein sources for vegetarian diets
- ☐ ↑ beans, lentils, peas
- ☐ Limit high fat meats

Fruits and Vegetables

- ☐ 2 - 4 Fruits daily or more
- ☐ 3 - 5 Vegetables daily or more
- ☐ Vitamin C sources
- ☐ Vitamin A sources

Calcium

- ☐ 3 - 4 servings daily
- ☐ Encourage nonfat or 1% milk
- ☐ ↓ high fat choices
- ☐ ↑ low lactose alternatives
- ☐ ↑ calcium-fortified foods

Snacks

- ☐ ↓ high sugar snacks
- ☐ ↓ high fat snacks
- ☐ ↑ fruit/vegetable snacks
- ☐ ↓ fast food

Drinks

- ☐ Limit juice: 1/day (4-8 oz. total)
- ☐ Drink 100% juice
- ☐ Drink 8-12 glasses water/day (8 oz. each)
- ☐ Discourage fruit drinks
- ☐ Discourage soda/caffeine
- ☐ Discourage alcohol

0306.132.H49

Name__________________ Age__________ Date of Birth__________ Date__________

Don't Stop! Please turn me over. . .

Youth Nutrition and Activity Assessment
(Ages 8-21)

Provide additional information on your food, activity and health habits.

Health professionals: Complete assessment in the shaded boxes below using all information provided.

Eating Habits:

Do you eat or drink:	Yes	No	Examples/Comments
◗ breakfast?	❑	❑	________
◗ morning snack?	❑	❑	________
◗ lunch?	❑	❑	________
◗ afternoon snack?	❑	❑	________
◗ dinner?	❑	❑	________
◗ evening snack?	❑	❑	________
◗ milk?	❑	❑	________
◗ soda, coffee, tea?	❑	❑	________
◗ beer, wine or other alcohol?	❑	❑	________

Eating Habits:

Yes	No	
❑	❑	Is the overall diet adequate? Does it include: ❑ 3 meals/2 snacks ❑ high iron foods ❑ calcium foods ❑ 5 or more fruits and vegetables ❑ adequate fluids
❑	❑	Is hgb/hct within normal limits?
❑	❑	Has there ever been a lead test?________
❑	❑	Counseling given (topics):________
❑	❑	Further counseling needed (topics):________
❑	❑	Referral made to:________

Exercise/Physical Activity:

◗ How many hours per day do you:
- ◗ watch TV? ______hours per day
- ◗ play video/computer games? ______hours per day
- ◗ surf the internet/chat rooms? ______hours per day

◗ *(Circle all that apply)* Do you walk, run, bicycle, rollerblade or dance? Do you play basketball, softball, soccer, volleyball, other team sports?

◗ Do you participate in physical education classes at school?
❑ Yes ❑ No

◗ Other activities________________

◗ How often are you physically active?
______times per week ______minutes each time

Yes	No	
❑	❑	Limit use of TV/computer/video/internet (1-2 hours/day or less) Goals set?________
❑	❑	Encourage activity (60 minutes/day or more) Goal set?________
❑	❑	Referral made to:________

Weight/Body Image:

◗ Are you trying to:
❑ lose weight ❑ gain weight ❑ stay the same?

◗ Do you eat less to control your weight? ❑ Yes ❑ No
Explain:________________

◗ Have you ever made yourself vomit? ❑ Yes ❑ No
If yes, how often?______When was the last time?______

◗ Do you ever "binge" eat? ❑ Yes ❑ No
If yes, how often? ______ When was the last time?______

◗ Are you currently using diet pills, laxatives, supplements, steroids, protein powders? ❑ Yes ❑ No

◗ Other products used________________

BMI________________Date__________

❑	Acceptable Range	BMI between 5th and 85th percentile
❑	At risk of overweight	BMI for age > 85th percentile, < 95th percentile
❑	Overweight	BMI for age ≥ 95th percentile
❑	Underweight	BMI for age ≤ 5th percentile

Yes	No	
❑	❑	General signs of an eating disorder?
❑	❑	Understands healthy eating?
❑	❑	Counseling given? Topics:________
❑	❑	Referral made to:________

Completed by Name/Title:________________________________ **Date:**__________

Developed by the CHDP Nutrition Sub-Committee in cooperation with Department of Public Health, Human Services System, County of San Bernardino and Department of Public Health, Community Health Agency, County of Riverside 0306-224.ai MDS Rev 10/01

DHCS 4466 (09/07)

What Does Your Child Eat?

Circle the foods your child ***eats*** every day or at least 3 times per week:

Baby Foods

Breast Feeding, Formula with iron, Cereal with iron, Vegetable, Meat, Juice, Egg, Honey, Fruit, Beans, Tofu, Crackers, Corn Syrup

How does your child feel about mealtimes?

Breads, Grains, and Cereals

Rice, Soup Noodles, Tortilla, Pasta, Cereal with iron, Crackers, Pretzels, Bread/Bagel, Sweet Breads

Fruits and Vegetables/Vitamin A, C, Folic Acid, and Fiber Rich Foods

C, A

100% Juice, Strawberries, Cantaloupe, Mango, Peaches, Watermelon, Pineapple, Apple, Grapes, Pear, Orange, Tomato, Cauliflower, Dark Green Leafy Vegetables, Carrot, Squash (zucchini), Banana, Raisins, Broccoli, Bell Pepper/Chili, Cabbage, Salad, Potatoes/ Sweet Potatoes, Green Beans & Peas, Corn

Milk Products/Calcium Rich Foods

Milk Shake, Whole Milk, 1% Milk/ Skim Milk, Nonfat/Lowfat Cottage Cheese, Cheese, Calcium Fortified 100% Juice, Calcium Fortified Soy Milk, Nonfat/Lowfat yogurt, Ice Cream, Calcium Fortified Tofu

Protein/Iron Rich Foods

Chicken/Turkey, Beef, Fish/Canned Fish, Taco, Ham/Pork, Egg, Peanuts, Spaghetti With Meatballs, Tofu, Liver, Dried beans/Lentils

Other Foods

Hotdog, Hamburger, Chips, Candies, Chocolate Bar, Pizza, Fried Chicken, French Fries, Burrito, Flavored Drink, Cookies

Circle if baby/child uses:

Vitamins

Circle if your baby or child receives food from:

Food Stamps **School Lunch** **Head Start** **WIC**

Circle activities your baby or child does every day.

Drinks water?

Child's name:____________________ **Record #:**__________

Age: ____ **yrs.** ____ **mos. Wt:** ____ **lbs. Ht:** ____ **in. Date:** ___/___/___

Office Use Only
Feeding milestones to check/visit

Baby: Birth to 24 months

Yes / No

- ☐ ☐ Breast-fed 8–12 times/24 hours during early weeks of lactation OR every 3–4 hours/day for older infants?
- ☐ ☐ Formula-fed w/iron no less than 20 ounces/day? Correct dilution?
- ☐ ☐ No honey/Karo Syrup until 1 year?
- ☐ ☐ 4–6 months: Start on baby cereal with iron?
- ☐ ☐ 5–7 months: Start on pureed vegetables and fruits?
- ☐ ☐ 6–7 months: Drink from a cup?
- ☐ ☐ 6–8 months: Start on pureed or ground meat, i.e., poultry, beef, pork, fish, egg yolk, beans, tofu?
- ☐ ☐ 7–9 months: Eats finger foods and mashed/chopped foods, NO grapes, nuts, popcorn, hotdogs, hard candy?
- ☐ ☐ 1 year: Drinks regular milk no less than 16 ounces/day?
- ☐ ☐ 9–12 months: Feeds self, joins family meal and snack times?
- ☐ ☐ 12–24 months: Eats variety of foods: small portions, i.e., 1–2 Tbsp., ½ c juice, ½ slice of bread.

Child: 2 to 8 years

Yes / No

- ☐ ☐ Eats recommended variety and amounts of foods daily for age from the food guide pyramid?

Limit Fats and Sweets; Milk (Calcium) 2–3 servings; Protein (Iron) 2–3 servings; Vegetables 3–5 servings; Fruits 2–4 servings; Breads, Grains, and Cereals 6–11 servings

Mealtime/Others:

Yes / No

- ☐ ☐ Set meal and snack times?
- ☐ ☐ Brush teeth by himself at 5 years?
- ☐ ☐ Good food supply?
- ☐ ☐ Takes vitamins, iron, or fluoride?
- ☐ ☐ Growing normally according to his/her growth patterns?
- ☐ ☐ Does child play with or eat dirt, plaster, clay, and paint chips?
- ☐ ☐ Any food intolerances or allergies?

____

- ☐ ☐ Referral for identified nutrition problem? Where? __________

Activity:

- ☐ ☐ Actively plays everyday, i.e., running, biking, sports, 1 hour/day?
- ☐ ☐ TV viewing: 2 hours or less/day?

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

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 __________

Childhood Lead Poisoning Prevention Program(CLPPP)

LEAD RISK ASSESSMENT QUESTIONNAIRE
CUESTIONARIO DE EVALUACIÓN DE LOS RIESGOS DEL PLOMO

For children NOT PARTICIPATING in federally funded program. *Para niños que NO PARTICIPAN en programas Federales*

The following questions are to be answered by the parents/guardians of children at 12 and 24 months of age, or between 25 and 72 months, if no previous assessment or test has been done. *Las siguientes preguntas son para ser contestadas por los padres o tutores de niños de 12 meses y 24 meses de edad, o dentro de 25 y 72 meses de edad, si no se les han hecho estas preguntas anteriormente.*

1. Does your child live in, or spend a lot of time in, a place built before 1978 that has peeling or chipped paint or that has been recently renovated?
   ¿Vive su niño (a) ó pasa mucho tiempo en alguna casa o edificio que fue construida antes de 1978 en donde se esté descascarando la pintura o ha sido remodelada recientemente?
   ☐ Yes/*Si* ☐ No ☐ Don't Know/*No se*

2. Do you use imported or home-made dishes or containers to serve, prepare, or store food or drinks? (Clay pots, lead-soldered pots, ceramic ware, leaded glass)
   ¿Usa usted ollas, trastes o vasos importados de otros países o hechos a mano para preparar, servir, o guardar comida, o bebidas? (jarros o cazuelas de barro, ollas soldadas con plomo, vasos de vidrio que contengan plomo).
   ☐ Yes/*Si* ☐ No ☐ Don't Know/*No se*

3. Does your child live with someone whose job or hobby involves lead? (Paint removal, furniture refinishing, welding, soldering, automobile assembly, battery manufacturing or recycling, radiator repair, gardening, or making pottery)
   ¿Vive su niño(a) con alguien que está expuesto al plomo en su trabajo, o en algún pasatiempo? (Pintando, soldando, fabricando o reciclando baterias de autos, reparando carros, o hacienda ceramica)
   ☐ Yes/*Si* ☐ No ☐ Don't Know/*No se*

4. Does your child put non-food items in his/her mouth (dirt, soil, paint chips, lead bullets, batteries, keys etc.)? *¿Su niño(a) se lleva a la boca objetos no comestibles? (tierra, pintura descascarada, balas hechas de plomo, baterías, llaves, etc.)*
   ☐ Yes/*Si* ☐ No ☐ Don't Know/*No se*

5. Does your family use home remedies such as Greta, Azarcon, or Estomaquil?
   ¿Usa su familia remedios caseros como Greta, Azarcón, o Estomaquil?
   ☐ Yes/*Si* ☐ No ☐ Don't Know/*No se*

6. Does your child eat imported candies such as Pelon Rico, Chaca Chaca, or Lucas Acidito?
   ¿Come su hijo(a) Dulces importados como Pelon Rico, Chaca Chaca, o Lucas Acidito?
   ☐ Yes/*Si* ☐ No ☐ Don't Know/*No se*

VALENTINE MEDICAL CLINIC
16070 Tuscola Rd Suite 101
Apple Valley, CA 92307
Phone (760)267-9931 - Fax (760)267-9933

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:____________________

Revision Date 6/ 01/2010

COMMUNICATION CONSENT AGREEMENT

I UNDERSTAND 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:** ______________

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. <u>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?</u>
¿Acasoested (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)*

AUTHORIZATION TO TREAT A MINOR

I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the attending physician for the treatment/diagnosis of

____________________, ____________________.
Minor's Name Minor's Birthdate

I hereby authorize the physician to release any information acquired in the course of the minor's examination or treatment.

____________________ __________
Signature of Parent/Guardian Date

AUTORIZACIÓN DE UNA TERCERA PERSONA PARA DAR TRATAMIENTO MEDICO A UN MENOR DE EDAD

(Yo) (Nosotros), padre(s), madre, del suscrito(a) y con la custodia/tutela legal de ____________________, menor de edad, por medio de ésta autorizo
Nombre del Menor

(amos) a Valentine Oturkere, MD, MPH como agente(s) del suscrito(a) y doy (damos) nuestro consentimiento para que le tomen radiografias, le hagan pruebas da diagnóstico (incluyendo análisis de sangre, orina, pruebas en la piel, Immunizaciones) y tratamiento medico externo (no incluyendo cirugia). Que se considere prudente y que se efectúe bajo la supervision general o especial de un Doctor en Medicina, con autorización para practicar de acuerdo a lo previsto en el Acta de Practica Medica (Medical Practice Act), ya sea que dichos tratamientos or diagnósticos se efectúen en

VALENTINE MEDICAL CLINIC(nombre de la Clinica).

____________________ __________
Padre/Madre/ Tutor Legal Fecha

Valentine Medical Clinic

16070 Tuscola Rd Suite 101
Apple Valley, CA 92307
Phone (760)267-9931 - Fax (760)267-9933

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

Name of Physician/Health Care Provider/Other	
Address	**City/State/Zip Code**
Fax Number	**Phone Number**

TO

Name of Physician/Health Care Provider/Other	
VALENTINE MEDICAL CLINIC	
Address	**City/State/Zip Code**
16070 Tuscola Rd Suite 101	
Apple Valley, CA 92307	
Fax Number	**Phone Number**
(760)267-9933	(760)267-9931

☐ 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.

Patients may not be considered for dismissal for either of the following listed reasons:

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

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