

# Valentine Medical Clinic **[PEDIATRIC]**

8990 Garfield St Suite 6

Riverside, CA 92503

(Please Print)

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

Date

## PATIENT INFORMATION

Last Name			First Name			Middle Initial /AKA		
Date of Birth			Social Security Number			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married			<input type="checkbox"/> Life Partner <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other					
Race			Language:			Email Address		
Home Address			Apt #		City		State	Zip Code
Home Phone			Cell Phone			Other Phone <input type="checkbox"/> Work		
Employment Status			<input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Employed Part Time <input type="checkbox"/> Student <input type="checkbox"/> Child <input type="checkbox"/> Not Employed <input type="checkbox"/> Homemaker			<input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Active Duty Military <input type="checkbox"/> Self Employed <input type="checkbox"/> Other		

## PARENT/GUARDIAN INFORMATION

Relationship to Patient			<input type="checkbox"/> Self (If self, skip to Emergency / Next of Kin) <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> 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 <input type="checkbox"/> Work		
Employer			Employer Phone Number					
Employment Status			<input type="checkbox"/> Active-Duty Military <input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Not Employed <input type="checkbox"/> Student <input type="checkbox"/> Child			<input type="checkbox"/> Employed Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Homemaker <input type="checkbox"/> Self Employed <input type="checkbox"/> 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 <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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 1st 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: \_\_\_\_\_

# What do you eat?

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

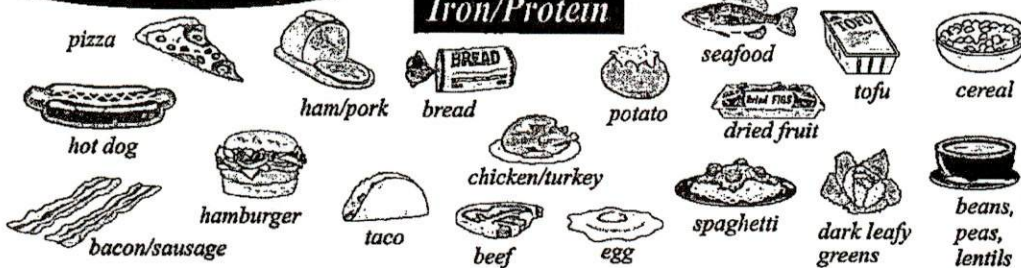
Time Amount Food or Drink

10:00 a.m. 1/2 cup Carrots

Was yesterday a typical day? Yes No

Circle the foods you eat often.

## Iron/Protein



## For office use only

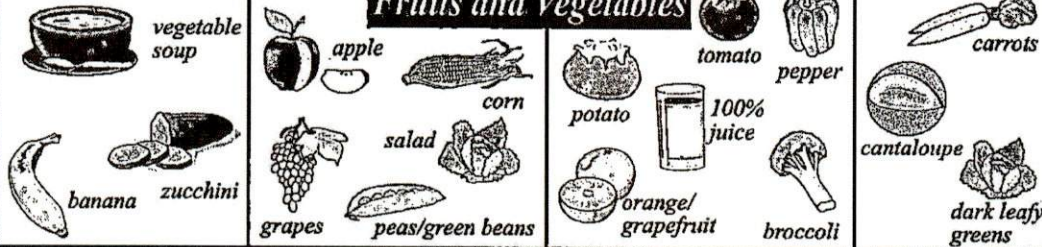
(Check (✓) topics discussed)

- 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

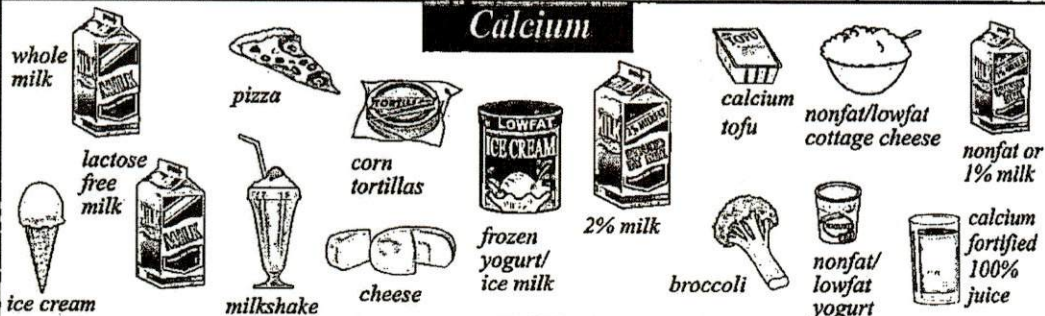
## Fruits and Vegetables



## Fruits and Vegetables

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

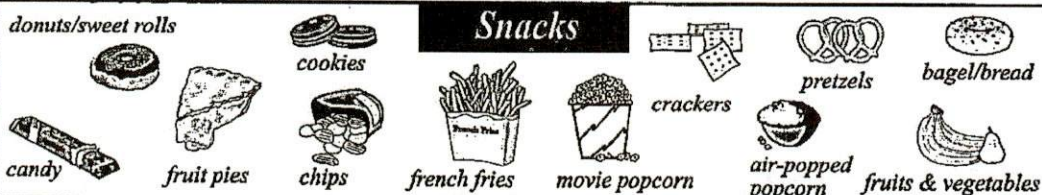
## Calcium



## Calcium

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

## Snacks



## Snacks

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

## Drinks



## 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

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

# 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?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▶ morning snack?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▶ lunch?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▶ afternoon snack?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▶ dinner?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▶ evening snack?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▶ milk?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▶ soda, coffee, tea?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▶ beer, wine or other alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____

### Eating Habits:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Is the overall diet adequate? Does it include:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 3 meals/2 snacks
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> high iron foods
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> calcium foods
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 5 or more fruits and vegetables
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> adequate fluids
<input type="checkbox"/>	<input type="checkbox"/>	Is hgb/hct within normal limits?
<input type="checkbox"/>	<input type="checkbox"/>	Has there ever been a lead test? _____
<input type="checkbox"/>	<input type="checkbox"/>	Counseling given (topics): _____
<input type="checkbox"/>	<input type="checkbox"/>	Further counseling needed (topics): _____
<input type="checkbox"/>	<input type="checkbox"/>	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	
<input type="checkbox"/>	<input type="checkbox"/>	Limit use of TV/computer/video/internet (1-2 hours/day or less) Goals set? _____
<input type="checkbox"/>	<input type="checkbox"/>	Encourage activity (60 minutes/day or more) Goal set? _____
<input type="checkbox"/>	<input type="checkbox"/>	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	
<input type="checkbox"/> Acceptable Range	BMI between 5th and 85th percentile	
<input type="checkbox"/> At risk of overweight	BMI for age ≥ 85th percentile, < 95th percentile	
<input type="checkbox"/> Overweight	BMI for age ≥ 95th percentile	
<input type="checkbox"/> Underweight	BMI for age ≤ 5th percentile	
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	General signs of an eating disorder?
<input type="checkbox"/>	<input type="checkbox"/>	Understands healthy eating?
<input type="checkbox"/>	<input type="checkbox"/>	Counseling given? Topics: _____
<input type="checkbox"/>	<input type="checkbox"/>	Referral made to: _____

**Completed by Name/Title:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# What Does Your Child Eat?

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

<b>Baby Foods</b> 		How does your child feel about mealtimes? 
<b>Breads, Grains, and Cereals</b> 		
<b>Fruits and Vegetables/Vitamin A, C, Folic Acid, and Fiber Rich Foods</b> 		
<b>Milk Products/Calcium Rich Foods</b> 		<b>Protein/Iron Rich Foods</b> 
<b>Other Foods</b> 		
Circle if baby/child uses: 		
Circle if your baby or child receives food from: <b>Food Stamps    School Lunch    Head Start    WIC</b>		<b>Child: 2 to 8 years</b> Yes / No <input type="checkbox"/> <input type="checkbox"/> Eats recommended variety and amounts of foods daily for age from the food guide pyramid? 
Circle activities your baby or child does every day. 		

**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.

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**Child: 2 to 8 years**  
Yes / No

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

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**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? \_\_\_\_\_

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**Activity:**

Actively plays everyday, i.e., running, biking, sports, 1 hour/day?

TV viewing: 2 hours or less/day?

Child's name: \_\_\_\_\_ Record #: \_\_\_\_\_  
 Age: \_\_\_\_\_ yrs. \_\_\_\_\_ mos. Wt: \_\_\_\_\_ lbs. Ht: \_\_\_\_\_ in. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



**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? (járros 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 baterías de autos, reparando carros, o hacienda cerámica)*  
 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

# 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 \_\_\_\_\_

## 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 Ouchere, MD, MPH como agente(s) del suscrito(a) y doy (damos) nuestro consentimiento para que le tomen radiografías, le hagan pruebas de diagnóstico (incluyendo análisis de sangre, orina, pruebas en la piel, inmunizaciones) y tratamiento médico externo (no incluyendo cirugía). Que se considere prudente y que se efectúe bajo la supervisión general o especial de un Doctor en Medicina, con autorización para practicar de acuerdo a lo previsto en el Acta de Práctica Médica (Medical Practice Act), ya sea que dichos tratamientos o diagnósticos se efectúen en

VALENTINE MEDICAL CLINIC (nombre de la Clínica).

\_\_\_\_\_  
Padre/Madre/ Tutor Legal

\_\_\_\_\_  
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)			
<input type="checkbox"/> Home Telephone Number	<input type="checkbox"/> Work Telephone Number	<input type="checkbox"/> Written Correspondence Mail/Delivery Service	<input type="checkbox"/> Other
<input type="checkbox"/> Leave call back number only: Do not leave message	<input type="checkbox"/> Leave call back number only: Do not leave message	<input type="checkbox"/> Fax #	
<input type="checkbox"/> Okay to leave detailed message with person	<input type="checkbox"/> Okay to leave detailed message with person		
<input type="checkbox"/> Okay to leave detailed message on answering machine	<input type="checkbox"/> Okay to leave detailed message on personal voice mail		

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**VALENTINE MEDICAL CLINIC**

8990 Garfield St Suite 6

Riverside, CA 92503

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

**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 disclosure 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 affect 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](http://www.mbc.ca.gov)

Patient's Name \_\_\_\_\_  
PLEASE PRINT

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Represenative \_\_\_\_\_  
PLEASE PRINT

Relationship to 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 afirmativa a cualquiera de las siguientes 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 usted (o su hijo/a) recibió a un resultado positivo 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 algún contacto cercano o algún miembro de la familia que haya sido declarado enfermo de TB o que se sospeche tener esta enfermedad?*  
YES / SI  NO
  
3. Were you (was your child) born in or travel to high TB prevalence countries? (Africa, Asia, or Latin America)  
*¿Nació usted (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 familiares 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 usted (su hijo/a) haya sido diagnosticado(a) con algún tipo de infección como el sida o con problemas con su sistema inmuno?*  
YES / SI  NO
  
6. Do you (does your child) live with any individual who is HIV positive?  
*¿Acaso usted (o su hijo/a) haya sido declarado positivo con el examen del sida?*  
YES / SI  NO
  
7. Do you (does your child) live in an "out of home" placement facility?  
*¿Acaso usted (su hijo/a) se encuentra viviendo temporalmente en un hogar o local sostenido por el gobierno o asistencia 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 usted (o su hijo/a) vive con adultos que hayan estado presos or cualquier motivo en los últimos 5 años?*  
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 usted (o su hijo/a) vive o se asocia frecuentemente con personas que viven en las calles, que sean trabajadores temporales del campo, utilicen drogas ilícitas inyectables o que residan en asilos o en hospitales de convalecencia?*

YES / SI

NO

10. Do you (does your child) consume alcoholic beverages?

*¿Usted (su hijo/a) consume alcohol?*

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)*

*\*Cualquier persona que tiene un alto riesgo de contraer TB debe hacerse el examen de la tuberculosis cada año. (se les examina a los 4 y 5 años y de los 13 a 16 años)*



# Valentine Medical Clinic

8990 Garfield St Suite 6

Riverside, CA 92503

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\*

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

FROM

TO

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

<b>Name of Physician/Health Care Provider/Other</b>	
VALENTINE MEDICAL CLINIC	
<b>Address</b>	<b>City/State/Zip Code</b>
8990 Garfield St Suite 6	
Riverside, CA 92503	
<b>Fax Number</b>	<b>Phone Number</b>
(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.

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 DISCLOSED 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