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MEDICAL CLINIC

PATIENT REGISTRATION

PATIENT INFORMATION

NAME: _____ Email: _____
(First) (Middle initial) (Last)

ADDRESS: _____
(Number and street) (Apt #) (City) (State) (Zip code)

PRIMARY PHONE #: _____ SECONDARY PHONE #: _____ AGE: _____
(Cell or home) (Cell or home)

BIRTH DATE: _____ GENDER: ☐Female ☐Male MARITAL STATUS: _____

RACE: _____ PRIMARY LANGUAGE: _____ SS #: _____

ETHNICITY: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Unknown ☐Declined

EMPLOYER / SCHOOL: _____ EMPLOYER PHONE: _____

ADDRESS: _____
(Number and street) (Apt #) (City) (State) (Zip code)

OCCUPATION: _____ BY WHOM WERE YOU REFERRED: _____

OTHER PHYSICIANS INVOLVED IN YOUR CARE: _____

IN CASE OF AN EMERGENCY

NAME: _____ RELATIONSHIP: _____

PHONE#: _____ ALTERNATE PHONE#: _____

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE NAME _____

_____
ID# GROUP#

_____
POLICY OWNER NAME & RELATIONSHIP TO PATIENT

SECONDARY INSURANCE

INSURANCE NAME _____

_____
ID# GROUP#

_____
POLICY OWNER NAME & RELATIONSHIP TO PATIENT

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

X _____ _____
Signed Date

Rev 03/2014

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MEDICAL CLINIC

New Patient Medical History

Name:_____Date of Birth:____/___/ 19___Age:_____Sex: _____
How did you hear about our practice?

Past Medical History

Condition / Disease	*Year Began*	*Condition / Disease*	*Year Began*
❑ Hypertension		Other(s):	
❑ High Cholesterol			
❑ Hypothyroidism (low thyroid)			
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ GERD			
❑ Depression or Anxiety			
❑ Heart Problems -			

Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures

Operation / Hospitalization / Injury	*Month / Yr*	*Operation / Hospitalization / Injury*	*Month / Yr*

Medication or Food Allergies or Intolerances

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	*Reaction*	*Medication / Food*	*Reaction*

Medications, Vitamins and Herbal Supplements

Medication	*Strength*	*Number of pills taken & frequency*	*Medication*	*Strength*	*Number of pills taken & frequency*
Example: *Tylenol*	*500 mg*	*1 - twice daily*			

Social, Educational and Work History

Marital Status:	Age of children, if any:	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation:	Hours worked per week:
Highest Level of Education:	Completed at which institution / school:	
What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
What are your hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?

Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

Family Health History

Please list below the health history of your blood (genetic) first degree relatives

Relative	***Living or Deceased***	***Current age or age at death***	***Cause of Death***	***Health Problems***
Father:				
Mother:				
Brother(s):				
Sister(s):				

Review of Systems

Please review the following symptoms and circle those items that are a problem for you

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

- ❑ ***Place an "X" in the box to the left if you have none of the above.***

Disease Prevention and Health Maintenance

Please list below the most recent dates of your vaccines and health screening tests

	Month/Yr		***Month/Yr***		***Month/Yr***
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Ab Aneurysm Screen	
Gardasil Vaccine		Chest X-Ray		HIV Test	

Advance Health Care Directive Form Instructions

You have the right to give instructions about your own health care.

You also have the right to name someone else to make health care decisions for you.

The Advance Health Care Directive form lets you do one or both of these things. It also lets you write down your wishes about donation of organs and the selection of your primary physician. If you use the form, you may complete or change any part of it or all of it. You are free to use a different form.

INSTRUCTIONS

Part 1: Power of Attorney

Part 1 lets you:

- **name** another person as **agent** to make health care decisions for you if you are unable to make your own decisions. You can also have your agent make decisions for you right away, even if you are still able to make your own decisions.
- **also name** an **alternate agent** to act for you if your first choice is not willing, able or reasonably available to make decisions for you.

Your **agent** may not be:

- an operator or employee of a community care facility or a residential care facility where you are receiving care.
- your supervising health care provider (the doctor managing your care)
- an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Your **agent** may make all health care decisions for you, unless you limit the authority of your agent. You do not need to limit the authority of your agent.

If you want to limit the authority of your agent the form includes a place where you can limit the authority of your agent.

If you choose not to limit the authority of your agent, your agent will have the right to:

- Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
- Choose or discharge health care providers (i.e. choose a doctor for you) and institutions.
- Agree or disagree to diagnostic tests, surgical procedures, and medication plans.
- Agree or disagree with providing, withholding, or withdrawal of artificial feeding and fluids and all other forms of health care, including cardiopulmonary resuscitation (CPR).
- After your death make anatomical gifts (donate organs/tissues), authorize an autopsy, and make decisions about what will be done with your body.

Part 2: Instructions for Health Care

You can give specific instructions about any aspect of your health care, whether or not you appoint an agent.

There are choices provided on the form to help you write down your wishes regarding providing, withholding or withdrawal of treatment to keep you alive.

You can also add to the choices you have made or write out any additional wishes.

You do not need to fill out part 2 of this form if you want to allow your agent to make any decisions about your health care that he/she believes best for you without adding your specific instructions.

Part 3: Donation of Organs

You can write down your wishes about donating your bodily organs and tissues following your death.

Part 4: Primary Physician

You can select a physician to have primary or main responsibility for your health care.

Part 5: Signature and Witnesses

After completing the form, **sign and date it** in the section provided.

The form must be signed **by two qualified witnesses** (see the statements of the witnesses included in the form) **or** acknowledged before a notary public. **A notary is not required if the form is signed by two witnesses. The wittnesses must sign the form on the same date it is signed by the person making the Advance Directive.**

See part 6 of the form if you are a patient in a skilled nursing facility.

Part 6: Special Witness Requirement

A Patient Advocate or Ombudsman must witness the form ***if you are a patient in a skilled nursing facility*** (a health care facility that provides skilled nursing care and supportive care to patients). See Part 6 of the form.

You have the right to change or revoke your Advance Health Care Directive at any time

If you have questions about completing the Advance Directive in the hospital, please ask to speak to a Chaplain or Social Worker.

We ask that you
complete this form in English
so your caregivers can understand your directions.

Advance Health Care Directive

Name_____

Date_____

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form also lets you write down your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or change all or any part of it. You are free to use a different form.

You have the right to change or revoke this advance health care directive at any time.

Part 1 — Power of Attorney for Health Care

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

Name of individual you choose as agent:_____

Relationship_____

Address: _____

_____

Telephone numbers: (Indicate home, work, cell) _____

ALTERNATE AGENT (Optional): If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Name of individual you choose as alternate agent:_____

Relationship_____

Address: _____

_____

Telephone numbers: (Indicate home, work, cell) _____

SECOND ALTERNATE AGENT (optional): If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Name of individual you choose as second alternate agent: _____

Address: _____

_____

Telephone numbers: (Indicate home, work, cell) _____

(1.2) AGENT'S AUTHORITY: My agent is authorized to 1) make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, 2) to choose a particular physician or health care facility, and 3) to receive or consent to the release of medical information and records, except as I state here:

_____

_____

(Add additional sheets if needed.)

(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I initial the following line.

If I initial this line, my agent's authority to make health care decisions for me takes effect immediately. ____

(1.4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) AGENT'S POST DEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

_____

_____

(Add additional sheets if needed.)

(1.6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named. _____ (initial here)

Part 2 — Instructions for Health Care

If you fill out this part of the form, you may strike out any wording you do not want.

(2.1) END-OF-LIFE DECISIONS: I direct my health care providers and others involved in my care to provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

☐ a) Choice Not To Prolong
I do not want my life to be prolonged if the likely risks and burdens of treatment would outweigh the expected benefits, or if I become unconscious and, to a realistic degree of medical certainty, I will not regain consciousness, or if I have an incurable and irreversible condition that will result in my death in a relatively short time.

Or

☐ b) Choice To Prolong
I want my life to be prolonged as long as possible within the limits of generally accepted medical treatment standards.

(2.2) OTHER WISHES: If you have different or more specific instructions other than those marked above, such as: what you consider a reasonable quality of life, treatments you would consider burdensome or unacceptable, write them here.

_____

_____

_____

_____

_____

Add additional sheets if needed.)

Part 3 — Donation of Organs at Death (Optional)

(3.1) Upon my death (mark applicable box):

☐ I give any needed organs, tissues, or parts

☐ I give the following organs, tissues or parts only:_____

☐ I do not wish to donate organs, tissues or parts.

My gift is for the following purposes (strike out any of the following you do not want):

Transplant Therapy Research Education

Part 4 — Primary Physician (Optional)

(4.1) I designate the following physician as my primary physician:

Name of Physician:_____

Address: _____

_____

Telephone: _____

Part 5 — Signature

(5.1) EFFECT OF A COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURE: Sign name: _____ Date: _____

(5.3) STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this advance directive in my presence (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly nor an employee of an operator of a residential care facility for the elderly.

FIRST WITNESS

Print Name: _____

Address: _____

Signature of Witness: _____ Date: _____

SECOND WITNESS

Print Name: _____

Address: _____

Signature of Witness: _____ Date: _____

(5.4) ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate on his or her death under a will now existing or by operation of law.

Signature of Witness: _____

Signature of Witness: _____

Part 6 — Special Witness Requirement if in a Skilled Nursing Facility

(6.1) The patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OF OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by section 4675 of the Probate Code:

Print Name:_____ Signature: _____

Address: _____ Date: _____

Certificate of Acknowledgement of Notary Public (Not required if signed by two witnesses)

State of California, County of _____ On this _____ day of _____ , _____ , before me, the undersigned, a Notary Public in and for said State, personally appeared _____ , personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument, and acknowledged

to me that he/she executed it.

WITNESS my hand an official seal. Seal

Signature_____

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MEDICAL CLINIC

Chronic Care Management Patient Consent

By signing this Agreement, you consent to: Iyabo O. Daramola, MD, and associates providing chronic care management services (referred to as "CCM Services") to you as more fully described below.

CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk of further decline.

CCM Services include 24-hours-a-day, 7-days-a-week access to a health care provider in Provider's practice to address acute chronic care needs; systematic assessment of your health care needs; processes to assure that you timely receive preventative care services; medication reviews and oversight; a plan of care covering your health issues; and management of care transitions among health care providers and settings. The Provider will discuss with you the specific services that will be available to you and how to access those services.

Provider's Obligations.

When providing CCM Services, the Provider must:

• Explain to you (and your caregiver, if applicable), and offer to you, all the CCM Services that are applicable to your conditions.

• Provide to you a written or electronic copy of your care plan.

• If you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

Beneficiary Acknowledgment and Authorization.

By signing this Agreement, you agree to the following:

• You consent to the Provider providing CCM Services to you.

• You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.

• You acknowledge that only one practitioner can furnish CCM Services to you during a calendar month.

• You understand that cost-sharing will apply to CCM Services, so you may be billed for a portion of CCM Services even though CCM Services will not involve a face-to-face meeting with the Provider.

2401 Reo Drive San Diego CA 92139
Telephone: (619)479-6767 Fax (619)434-8840

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MEDICAL CLINIC

Chronic Care Management Patient Consent

Beneficiary Rights.

You have the following rights with respect to CCM Services:

• The Provider will provide you with a written or electronic copy of your care plan.

• You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current month. You may revoke this agreement verbally by calling (619) 479-6767 or in writing to 2401 Reo Drive San Diego CA 92139-3025. Upon receipt of your revocation, the provider will give you written confirmation (including the effective date) of revocation.

Beneficiary Beneficiary's Representative and/or Caregiver (if applicable)

Signature: _____

Name: _____

Best Telephone number: _____

Relationship (if not patient): _____

Date: _____

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give consent to release this information to the family members indicated below. This consent form will not allow Caring Hearts Medical Clinic to release any other information to these family members.

You have the right to revoke this consent in writing.

I authorize/allow Caring Hearts Medical Clinic to release my medical and/or billing information to the following individual (s):

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

3. _____ Relation to Patient: _____

This does not serve as an Authorization to Release Medical Records

Myself only

Patient Signature: _____ Date: _____

AUTHORIZATION TO LEAVE MESSAGES WITH HOUSEHOLD MEMBERS/ANSWERING MACHINE:

Occasionally it is necessary for the staff of Caring Hearts Medical Clinic to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss or schedule test results, or to ask a patient to call regarding an issue or concern. At no time will a representative of Caring Hearts Medical Clinic discuss your medical condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent in writing.

Patient Signature: _____ Date: _____

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MEDICAL CLINIC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance of your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

I hereby acknowledge I have received a copy of the Notice of Privacy Practices from Caring Hearts Medical Clinic.

_____ _____

Signature – Patient or Representative Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because of the following reason(s):

□ Individual refused to sign

□ Communications barriers prohibited obtaining the acknowledgement

□ Other (Please Specify)

_____

Caring Hearts Medical Clinic
Patient Consent To Treatment Form

1. **Medical Consent:**
   I request and authorize my physician and other physicians who may attend to me, their associates and assistants, including those employed by the Caring Hearts Medical Clinic (hereinafter referred to as CHMC), its house staff, employees and supervised students to provide and perform such medical care. tests, procedures, drugs and other special services and tests ordered by my physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no representation, warranties, or guarantees as to results or cures have been made to, or relied upon, by me.
2. **Release of Information:**
   I understand and acknowledge there are instances when information concerning my care, including copies of my medical records and/or billing information pertaining to my medical care, must be used by CHMC or disclosed by CHMC to certain individuals or representatives of agencies or organizations in connection with my care, payment for my care, and other activities related to my care. I also acknowledge that these and other permitted uses and disclosures arc more fully described in the Caring Hearts Medical Clinic Notice of Privacy Practices.
3. **Assignment of Insurance Benefits:**
   In consideration of any and all medical services, care, drugs, supplies, equipment, and facilities furnished by CHMC and all attending physicians, I hereby irrevocably assign and transfer to said CHMC and all attending physicians, all insurance benefits now due and payable to me under any insurance policy or policies thereof that might be applicable. I hereby transfer payment of benefits for medical and/or surgical services rendered by physicians for whom CHMC is authorized to charge and bill. I understand that my obligations to pay all charges is not affected by the fact that I have insurance benefits and if my insurance company fails to pay all or any portion of these charges for any reason, I will be responsible for all sums due and owing CHMC.
4. **Guarantee of Account:**
   In consideration of any and all medical services rendered by CHMC to the above-named patient. I agree to pay CHMC the charges for all services ordered by the CHMC physicians, patient and patient's family including any deductibles, coinsurance or amounts not paid by the patient's insurance plan, including Medicare and Medicaid. If the requirements for referral, second opinion, or petrification of my care, as outlined by my insurance carrier, have not been followed, I understand that I will be responsible for all charges incurred.

   CHMC and the patient or patient's representative hereby enters into the above agreement. The patient or patient's representative certifies that he/she has read and accepted the above, where applicable to the patient's condition and status. and further certifies that he/she is the patient, or is duly authorized on behalf of the patient to execute such an agreement.

   _____

   Patient's Signature/Person Authorized to Consent and Relationship and Date

   _____

   Guarantor of Account if Other Than Patient and Relationship to Patient and Date

5. **Medicare Insurance Benefits:**
   I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct I authorize My holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or a related Medicare claim. 1request that the payment of authorized benefits be made on my own behalf. I understand I am responsible for the Part B deductible for each year, the remaining co-insurance and any other noncovered personal charges. I am also responsible for the Part A deductible for each occurrence of illness and any co-insurance amounts which may become due.

   _____

   Patient's Signature or Person Authorized to Consent and Relationship to Patient and Date

   _____

   Witness and Date

   I hereby certify that I have witnessed the signature(s) of the patient and/or individual signing on behalf of the patient.

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MEDICAL CLINIC

FINANCIAL POLICY AND ACKNOWLEDGEMENT FORM

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Always bring your current health insurance card to the office.

2. Please notify us at time of check-in of any changes in insurance, address, phone number, etc.

3. If you currently have no insurance, all services provided are to be paid in full at the time of service.

4. All co-payments and deductibles are due at the time of services.

5. Payments may be made with cash, personal check, Visa, or MasterCard.

6. Keep in mind that your insurance policy is basically a contract between you and your insurance company. We will file all insurance claims for you: however, the ultimate responsibility for payment is yours.

7. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

8. *As a courtesy to all scheduled patients, we ask that you give adequate notice (at least 24 hours) if you are unable to make a scheduled appointment. Those who do not give notice will be billed a $50 no show fee, for the missed appointment.*

9. Return Check Fee $25.

I acknowledge receipt of this Financial Policy and have read OR have had it read to me. I understand and agree to the provisions and terms as listed above.

_____ _____

Patient Signature Date

Pain Management Agreement

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This Agreement is to help you and your provider to comply with the law regarding controlled pharmaceuticals.

_____ I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.

_____ I understand that this Agreement is essential to the trust and confidence necessary for a provider/patient relationship.

_____ I understand that if I break this Agreement, my provider will stop prescribing these pain medicines.

_____ In this case, my provider will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

_____ I would also be willing to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my provider deems necessary.

_____ I will communicate fully with my provider about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

_____ I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to times when I am not driving or operating machinery and will be infrequent.

_____I will not share my medication with anyone.

_____ I will not attempt to obtain any controlled medications, including opioid medications, controlled stimulants, or anti-anxiety medications from any other provider.

_____ I will safeguard my pain medication from loss, theft, or unintentional use by others, including youth. Lost or stolen medications will not be replaced.

_____ I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

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

_____ I agree that I will submit to a blood or witnessed urine test if requested by my provider to determine my compliance with my pain medications.

_____ I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program web site periodically throughout my treatment period.

_____ I agree that I will use my medicine as prescribed and that use of my medicine at a greater rate will result in my being without medication for a period of time.

_____I will bring unused pain medicine to every office visit.

_____I agree to follow these guidelines that have been fully explained to me.

All my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on this _____day of _____, 201_.

Patient Signature: _____

Patient Name (printed): _____

Provider Signature: _____

Provider Name (printed): _____

Witnessed by:

Signature: _____

Name (printed):_____

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MEDICAL CLINIC

Iyabo Daramola M.D

Authorization to Release Health Care Information

Patients Name:
Date of Birth:
Social Security Number:

I request and authorize _____ to release health care information of the patient named above to:

Caring Hearts Medical Clinic
2401 Reo Drive San Diego, CA 92139
Phone 619-479-6767 Fax 619-434-8840

This request and authorization applies to:

X All health care information: ALL RECORDS

_____ Health care information relating to the following treatment, condition or dates:

_____

_____ Other: _____

DEFINITION: Sexually Transmitted Disease (STD) as defined by law, RCW 70, includes herpes, herpes simplex human papiloma virus, warts, genital warts, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancrold, lymphogranuloma venereuem, HIV, AIDS and gonorrhea.

X Yes ____ No I authorize the release of any records regarding drug, alcohol or mental treatment to the person(s) listed above.

X Yes ____ No I authorize the release of STD results, HIV/AIDS testing, whether negative or positive to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give written permission before disclosure of these test results to anyone.

Patient Signature: _____ Date Signed: _____

This release is valid for one year after signature date only.

Staying Healthy Assessment

Adult

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

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

Need Interpreter? ☐ Yes ☐ No

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

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

If yes, please describe:

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

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

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