



Rancho Paseo Medical Group

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information, about you.
Failure to provide all information requested may invalidate this Authorization.

First Name: _____ Mid. Initial _____ Last Name _____

Date of Birth: _____ Social Sec #: _____ Phone: _____

Address: _____ City _____ ST _____ Zip _____

I hereby authorize: _____

Address: _____ City _____ ST _____ Zip _____

Phone: _____ Fax: _____

to release to: Rancho Paseo Medical Group, 264 N. Highland Springs Ave. 5A, Banning, CA 92220
Ph: 951-769-0079, Fax: 951-845-6750

the following information:

- a. All health information pertaining to my medical history, mental or physical condition – OR
- Only the following records or types of health information. Include date(s) of treatment:

b. I specifically authorize release of the following information (check as appropriate):

- Mental health treatment information
- HIV test results
- Alcohol/drug treatment information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

Purpose of requested use or disclosure: Patient request ; OR other:

Expiration date: _____ (This authorization will expire in 6 months unless otherwise indicated).

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:
Rancho Paseo Medical Group, 264 N. Highland Springs Ave. 5A, Banning, CA 92220
- My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to and will receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by Federal confidentiality law (HIPAA).

If this is checked , the requestor will receive compensation for the use or disclosure of my information.

Signature: _____ Print: _____
(Patient/representative/spouse/financially responsible party)

Signature: _____ Print: _____
If signed by someone other than the patient, state your legal relationship to the patient:

Witness: _____ Date: _____

Rancho Paseo Medical Group Patient Registration Form

PATIENT INFORMATION					
Patients Last Name	First	MI	Marital Status	Date of Birth	Age
Patients Address	City	State	Zip	Home Phone No.	Social Security
PERSON RESPONSIBLE FOR EXPENSE (IF PATIENT IS UNDER 18)			EMPLOYER		
Last Name	First	MI	Name		
Address		Date of Birth	Address		
City	State	Zip	City	State	Zip
Relationship to Patient	Social Sec. No.		Phone No.	Fax	Mgr.
SPOUSE OF PERSON RESPONSIBLE			SPOUSE'S EMPLOYER		
Last Name	First	MI	Name		
Address		Date of Birth	Address		
City	State	Zip	City	State	Zip
Relationship to Patient	Social Sec. No.		Phone No.	Fax	MGR.
NEAREST RELATIVE			FIRST EMERGENCY CONTACT		
Name		Relationship to Pt.	Name		Relationship to Pt.
City	State	Zip	Phone	City	State
INSURANCE INFORMATION					
	Primary	Secondary	Eligibility Date		
Subscriber's Name					
Subscriber's SSN					
Subscriber's DOB					
Subscriber's Emp.					
Relationship to pt.					
Insurance I.D.					

INSURANCE AUTHORIZATION, ASSIGNMENT, AND MEDICAL RECORDS RELEASE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: "I authorize any holder of medical information about me to release said medical information requested by insurance companies with whom I have coverage or any public agency and its agents to determine benefits for services provided for related services. *Special authorization is needed to release any and all information regarding patients that are seen by a Behavioral Health*

I authorize the following individuals to have full access to my medical information, to receive results on my behalf from Rancho Paseo Medical Group and do authorize this disclosure after being provided any answers to questions regarding my privacy rights.

Names of Authorized Individuals to My Medical Records:
Relationship and Date-of-Birth: _____

ASSIGNMENT OF BENEFITS: I hereby authorize payment of benefits be made directly to Rancho Paseo Medical Group for services provided to me by Rancho Paseo Medical Group. I understand that I am financially responsible to Rancho Paseo Medical Group for charges not covered by this assignment. I authorize of overpaid insurance benefits where my coverages are subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees. I also am aware that I may be charged \$10 for missed appointments where I failed to give prior notice or cancellation. This authorization will remain in effect until revoked in writing by the undersigned.

Date _____

Signature of Patient _____
(If minor, responsible person)

Date _____

Witness _____

FINANCIAL DISCLOSURE STATEMENT

The following disclosure is furnished in compliance with Federal Truth-in-Lending Act.

Rancho Paseo Medical Group shall charge a FINANCE CHARGE on any part of the "previous balance" at the periodic rate of 1^{1/4}% per month after deducting current payments and/or credits received prior to the closing (billing) date of the statement. The ANNUAL PERCENTAGE RATE is 15% per annum. There shall be in all cases a minimum FINANCE CHARGE of \$.50 per month. Said minimum charge may result in an ANNUAL PERCENTAGE RATE in excess of 15% per annum. No FINANCE CHARGE will be charged on any "previous balance" as shown on the periodic statement, which is paid 90 days from the first billing of the "previous balance" or on any current charges listed on the periodic statement. The FINANCE CHARGES are figured on your account by applying the periodic rate to the amount you owe at the beginning of each billing cycle. All payments received shall be first applied to any FINANCE CHARGE assessed to the account, and then to that portion of the "previous balance" which is more than 90 days unpaid and then to that portion of the "previous balance" which is less than 91 days unpaid and then to the current charges listed on the periodic statement, and then finally to credit.

You may pay your entire balance at any time.

Any credit balances of \$5.00 or less will be automatically adjusted to \$0.00 due to the administrative costs of processing balances.

You are responsible for payment on your account regardless of Insurance. Rancho Paseo Medical Group cannot accept the responsibility for collecting your Insurance claims or negotiation of a settlement on a disputed claim. Notwithstanding Insurance benefits that may have accrued, the FINANCE CHARGES as set out above shall be assessed against all accounts, even if the account will ultimately be paid by Insurance benefits.

Rancho Paseo Medical Group will not acquire or retain any security interest in any property to secure the payment of credit extended for services rendered, except that Rancho Paseo Medical Group reserves the right to obtain assignment of benefits for payment of balances accrued to the group.

I certify that I have read this statement and have had an opportunity to review with the group personnel any questions I may have had regarding the same.

Patient's Signature: _____ Date: _____

CONSENT FOR TREATMENT

1. I hereby do voluntarily consent to such care including routine procedures and other treatment by Rancho Paseo Medical Group professionals and their assistants, appointees, or consultants as is necessary in their judgment.
2. I am aware that the practices of medicine, surgery and other health disciplines do not constitute exact sciences and I acknowledge that no guarantees have been made to me as to the result of treatments of examination by Rancho Paseo Medical Group.
3. I understand that for certain procedures deemed necessary by my physician, I will be required to sign a Special Consent Form. Further, if I don't fully understand a procedure or its risks, consequences, and alternate methods of treatment, I have the right to question the appropriate health care professionals.
4. I understand that Rancho Paseo Medical Group shall not be responsible or liable for the loss of/or damage to any personal property.
5. I authorize the release to any party responsible for such information from my records as is required in order for the group and all entities providing services to obtain payment. This includes records of alcohol and drug abuse and/or treatment, records of psychological services and social services, including communications made by the patient to a physician, social worker, or psychologist. This authorization shall be effective only so long as necessary to obtain payment or reimbursement and will end when payment or reimbursement is received.

I have read the above statement and my questions have been adequately answered and I certify that I understand its contents.

Print Patient Name: _____ Date of Birth: _____

Signature of Patient: _____ Date: _____

Signature of Patient or Guardian: _____ Relationship: _____

Signature of Witness: _____ Date: _____



ADVANCE DIRECTIVE QUESTIONNAIRE / CUESTIONARIO SOBRE DIRECTIVAS AVANZADAS

- 1) Have you formulated an Advance Directive?
Ha formulado usted una Directiva Avanzada? No Yes / Si
- 2) If you have formulated an Advance Directive, please check the type of directive:
Si ya ha formulado una Directiva Avanzada, por favor marque el tip que tiene
:
- a) Durable power of attorney for health care: /
Poder Durable de Abogado para Cuidado de Salud: _____
- b) California Natural Death Act: / *Acta de California de Muerte Natural*

- c) Living Health Care Will: / *Testamento de Cuidado de Salud en Vida:* _____
- d) Other: / *Otro:* _____
- 3) If you have formulated an Advance Directive, you hereby agree to furnish _____
with a copy within _____ days. /
Si ya usted ha formulado una Directiva Avanzada, acepta entregarnos una copia a
_____ *dentro de* _____ *dias.*
- 4) If you change, amend, alter or cancel your Advance Directive, you hereby agree to notify
_____ and provide _____ with a copy as soon as possible so that your
physician will be able to comply with your wishes. /
Si cambia, enmienda, altera o cancela su Directiva Avanzada acepta notificar a _____
Y proveer a _____ *a con una copia tan pronto le sea posible para que su medico de*
cabecera pueda cumplir con sus deseos.
- 5) Expiration date of Advance Directive, if any: _____.
(If the Advance Directive was formulated before 1991, it is "good" for only seven years. Advance Directives formulated after 1991 are "good"
indefinitely; unless you change/amend/cancel the Directive) /
Fecha de expiracion de la Directiva Avanzada, si la tiene _____.
(Si su directiva Avanzada fue formulada antes de 1991, estara vigente por solo 7 anos. Si fue formulada despues de 1991, estas estaran
vigentes indefinidamente a menos de que usted las cambia, enmiende o cancele).
- 6) I would like more information about Advance Directives. /
Quisiera mas informacion sobre Directivas Avanzadas. No Yes / Si
- 7) I do not wish to formulate or have an Advance Directive. /
No me interesa ninguna information acerca de Directivas Avanzadas. No Yes / Si

Patient Name / *Nombre de Paciente:* _____

Patient Signature / *Firma de Paciente:* _____ Date / *Fecha:* _____

Adult TB Exposure Risk Assessment

(Evaluation Questionnaire to determine if Mantoux tuberculin skin test (TST) is indicated.)

Name: _____ Medical Record #: _____

Age _____ DOB: _____ DOS: _____

The health care worker (HCW) is to ask the following questions during each periodic health assessment.

1. Have you or anyone you see regularly been diagnosed or suspected of being sick with active TB disease?
Yes _____ No _____
2. Do you have family members or frequent visitors who were born in high TB prevalence countries (most countries from Asia, Africa, Latin America, parts of Eastern Europe)? Yes _____ No _____
3. Were you born in, or travel to high TB prevalence countries (most countries from Asia, Africa, Latin America, parts of Eastern Europe)? Yes _____ No _____
4. Do you live in out of home placements (such as board & care or residential facilities)? Yes _____ No _____
5. Do you have HIV infection, or other immunosuppressive condition? Yes _____ No _____
6. Do you live with someone with HIV seropositivity? Yes _____ No _____
7. Do you live, or frequently visit, with persons who have been incarcerated in the last 5 years?
Yes _____ No _____
8. Do you live among or been frequently around individuals who are homeless, migrant workers, users of street drugs, or residents in nursing homes? Yes _____ No _____
9. Do you consume alcoholic beverages? Yes _____ No _____ If so, how much? _____

INSTRUCTIONS TO HEALTH CARE WORKER:

Administer the Mantoux TB skin test to all adults who have any of the above risk factors (indicated by a YES response) UNLESS:

1. The patient has a previous DOCUMENTED* positive Mantoux TST, or
2. The patient has had a TST within the last year.

NOTE:

Trained medical personnel must read the skin test.

*DOCUMENTED = Record indicating the date of Mantoux and the millimeter result.

Health Care Worker Completing form:

Completing form: _____ Date: _____

ADULT HEALTH HISTORY / HISTORIA DE SALUD ADULTO

Name/Nombre _____ Age/Edad _____ DOB/Cuando Nacio _____ Date/Fecha _____

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

Measles/Sarampion	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Rheumatic fever/Fiebre Reumatica	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si
Mumps/Paperas	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Heart Disease/Enfermedad del Corazon	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si
Chickenpox/Viruela	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Tuberculosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Venereal Disease/Enfermedad Veneria	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si
Strokes/Embolio	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Serious Disease/Enfermedad Graves	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si

Ever Hospitalized/Has sido hospitalizado No Yes/Si Explain/Explicacion _____

Ever had surgery/Ha tenido operaciones No Yes/Si Explain/Explicacion _____

Had broken bones/ha tenido fracturas No Yes/Si Explain/Explicacion _____

Head concussions or injuries/
Golpes o Heridas de cabeza No Yes/Si Explain/Explicacion _____

Date of Last Tetanus Shot/La Fecha de su ultima inmunizacion de Tetano _____

Date of Last PAP Smear/La Fecha de papanicolou exam de cancer. _____

Date of Last Mammogram/Mammographia _____

FAMILY HISTORY/HISTORIA FAMILIAR:

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

Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Who/Quien? _____
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Who/Quien? _____
Tuberculosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Who/Quien? _____
Heart trouble/Enfermedad del Corazon	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Who/Quien? _____
High blood pressure/Presion alta	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Who/Quien? _____
Stroke/Embolio	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Who/Quien? _____
Convulsions/Epilepcia	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Who/Quien? _____
Suicide/Suicidio	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Who/Quien? _____

SOCIAL HISTORY/HISTORIA SOCIAL:

Single/Soltero Married/Casado Separated/Separado Divorced/Divorciado Widowed/Viudo

Alcoholic Beverages/Bebidas Alcoholicas: Never/Nunca How much/Cuanto? _____

Tobacco or Cigarettes/Tobacco o Cigarillos: Never/Nunca. How much/Cuanto? _____

Are you sexually active?/Esta sexualmente activa(o)? Never/Nunca. How much/Cuanto? _____

What is your job?/Cual es su trabajo? _____

Education Level/Nivel de Education: 1 2 3 4 5 6 7 8 9 10 11 12 College/Colegio Superior 1 2 3 4

Ethnic Background/Nacionalidad: American Indian Asian Filipino Pacific Islander Black Hispanic White

SYSTEMIC REVIEW GENERAL? REVISION DE SISTEMAS:

Recent weight change/Reciente cambio de peso? No Yes/Si

Have you been in good health most of your life?/Ha tenido buena salud la mayor parte su vida? No Yes/Si

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

Skin/Piel	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Head-Eyes-Ears-Nose-Throat/Cabeza-Ojos-Oidos-Nariz-Garganta	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Neck/Cuello	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Lungs/Pulmones	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Heart and Circulation/Corazon o Circulacion	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Blood/Sangre	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Emotions/Emociones	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Nerves/Nervios	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Muscles and bones/Musculos o huesos	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Stomach and Bowels/Estomago o Intestinos	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Sex Organs/ Organos Sexuales	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Urinary/Urinaros	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Any other/Cualquier otro	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____

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

PATIENT SIGNATURE/FIRMA _____

DATE/FECHA _____

DOCTOR SIGNATURE _____

DATE/FECHA _____

Health History
 (Confidential)

Name _____ Age of patient _____ Date of Visit _____

PERSONAL HISTORY

Birthplace _____ Birthdate _____
 Education _____ Marital Status _____
 Health of Spouse _____
 Sleep (usual hours) _____ Aids to sleep _____
 Recreation _____
 Exercise _____
 Religion _____

MEDICINES TAKEN REGULARLY

Name	Dose	Reason

PERSONAL FAMILY HEALTH HISTORY

Check (✓) if you or your blood relatives have or have had any of the following:

You	Disease	Family	Relation to
	AIDS, HIV positive		
	Alcohol dependency		
	Allergies, hayfever		
	Anemia		
	Arthritis, gout		
	Asthma		
	Bleeding tendency		
	Cancer		
	Chronic lung disease		
	Convulsive disorder		
	Diabetes		
	Drug dependency		
	Heart disease		
	High blood pressure		
	Kidney disease		
	Leukemia		
	Mental illness		
	Migraines		
	Obesity		
	Peptic ulcer		
	Stroke		
	Thyroid trouble		
	Tuberculosis		
	Other		

ALLERGIES & SENSITIVITIES

List all substances, including drugs, to which you have had an adverse reaction

Substance	Describe reaction

OCCUPATIONAL CONCERNS

Your occupation _____

Check (✓) if your works exposes you to the following:

✓	Exposure	Describe
	Hazardous	
	Heavy lifting	
	Stress	
	Other	

HEALTH HABITS

Describe how much of each of these substances you use:

Caffine _____

Tobacco _____

Alcohol _____

Other _____

Circle "Yes" or "No"

Have you ever felt you should cut down on your drinking?	Yes	No
Have people annoyed you by criticizing your drinking?	Yes	No
Have you ever felt bad or guilty about your drinking?	Yes	No
Have you ever had a drink first thing in the morning to calm your nerves or get rid of a hang-over?	Yes	No

HOSPITALIZATIONS & SURGERIES

Year	Hospital	Reason for hospitalization

Have you ever had a blood transfusion? _____

If yes, please give approximate dates: _____

Rancho Paseo Medical Group
264 N. Highland Springs Ave., Ste. 5-A
Banning, CA 92220
951-769-0079, Fax: 951-845-6750

Name of Patient _____

Patient's Signature _____

Date _____

Notice of Privacy Practices

To The Patients of Rancho Paseo Medical Group. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: Rancho Paseo Medical Group, 264 North Highland Springs Ave., Ste. 5, Banning, California 92220 (951) 769-0079. Attention Administrator or Safety Officer.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: Rancho Paseo Medical Group, 264 North Highland Springs Avenue, Banning, California 92220 (951) 769-0079. Attention: Administrator or Practice Privacy Officer. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Rancho Paseo Medical Group, 264 North Highland Springs, Banning California 92220 (951) 769-0079. Attention Administrator or Practice Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Rancho Paseo Medical Group, Attention Administrator or Practice Privacy Officer, (951) 769-0079