Primaria Medical Clinic

222 W.6th St. Corona, CA. 92882
Tel: (951)278-2530 Fax: (951)278-9746

* BIENVENIDO*

INFORMACIÓN DEL PACIENTE:

Fecha De Hoy:_____

Nombre:_____
Dirección:_____
Ciudad:_____Estado____Zip_____
Licencia de manejar#:_____Vencimiento___
Estado Civil: S C V D
Empleador:_____
SSN:_____
Dirección:_____
Ciudad:_____ Estado _____Zip_____

Fecha de nacimiento:_____
Teléfono de la casa:( )_____
Celular:( )_____
Trabajo:( )_____
Departamento o Extensión:_____
Nombre del cónyuge:_____
Nombre de los padres:_____

CONTACTOS DE EMERGENCIA LOCAL:

Nombre:_____
Relación:_____
Teléfono:( )_____
Dirección:_____

Nombre:_____
Relación:_____
Teléfono :( )_____
Dirección:_____

SEGURO MÉDICO PRIMARIO:

Compañía de seguro:_____
Número de ID #:_____

SEGURO MÉDICO SECUNDARIA:

Compañía de seguro:_____
Número de ID #:_____

PROBLEMAS MÉDICOS:

1._____
2._____
3._____
4._____
5._____
6._____

ALERGIAS A MEDICAMENTOS:_____

MEDICAMENTOS: (Apuntar dosis e indicaciones)

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

FACTORES DE RIESGO:

Cigarrillos: Sí/No_____ Por día/Semana

Alcohol: Sí/No_____ Por día/Semana

¿Cómo se enteró de nuestra oficina?

_____ Pariente o Amigo_____ Plan de Seguros _____ Anuncio

_____ _____ _____

Firma del paciente Fecha Firma del medico

MUCHAS GRACIAS

Primaria Medical Clinic

Plan de sociedad con el paciente

Estimado paciente,

Bienvenido a nuestra práctica. Tenemos la intención de brindarle todo el cuidado y servicio que usted espera y se merece. Lograr la ***mejor salud posible*** requiere de una "sociedad" entre usted y su médico. Como nuestro "socio en la salud", le pedimos que nos ayude del siguiente modo:

Programando visitas con mi doctor para realizar exámenes físicos de rutina y otras pruebas de salud recomendadas
Comprendo que mi doctor me indicará cuáles pruebas de salud de rutina son adecuadas para mi edad, género y antecedentes personales y familiares. Comprendo que tendré que completar estas pruebas de salud recomendadas (mamografía, inmunizaciones, papanicolau, etc.). **Estas pruebas de salud son exámenes que pueden ayudar a detectar enfermedades o condiciones que ponen en riesgo la vida.** Si yo visito a mi médico para el tratamiento de problemas inmediatos y me olvido de programar una cita para realizar pruebas regulares de salud, corro el riesgo de que no se detecten problemas graves de salud. Yo programaré visitas regulares con mi médico para completar mi examen físico y conversar sobre estas pruebas de salud.

Realizando las visitas de seguimiento y reprogramando aquellas a las que no concurro
Entiendo que mi médico querrá saber cómo evoluciona mi condición después de que me retiro de la consulta. Volver a ver a mi doctor a tiempo le dará a él/ella la posibilidad de controlar mi condición y la respuesta al tratamiento. Durante una visita de seguimiento, mi médico podrá ordenar pruebas, referirme a un especialista, prescribir medicación, o hasta descubrir y tratar una condición seria de salud. Si no concurro a una consulta y no la programo nuevamente, corro el riesgo de que mi médico no pueda detectar y tratar una condición de salud seria. Haré todo lo posible por reprogramar la cita a la haya faltado lo antes posible.

Llamando a la oficina si no se me informa sobre los resultados de laboratorio y otras pruebas
Entiendo que mi médico me informará sobre los resultados de las pruebas de laboratorio y de otros exámenes tan pronto como pueda. Sin embargo, si me llaman de la oficina de mi médico en un tiempo específico, yo me pondré en contacto con la oficina para conocer los resultados de las pruebas.

Informaré a mi médico si decido *no* continuar el plan de tratamiento que él/ella recomiendan
Entiendo que después de examinarme, mi médico puede dar algunas recomendaciones basado en lo que él/ella considera que es mejor para mi salud. Esto puede incluir prescribir medicación, referirme a un especialista, ordenar análisis de laboratorio y otras pruebas, o hasta pedirme que regrese en un período de tiempo determinado. Entiendo *que no seguir* mi plan de tratamiento puede causar graves efectos negativos sobre mi salud. Le comunicaré a mi doctor si decido *no seguir* sus recomendaciones de modo que él/ella puedan informarme en detalle sobre los riesgos que implica mi decisión de retrazar o rechazar el tratamiento.

Gracias por ser socio. Como nuestro paciente, usted tiene el derecho a informarse sobre su cuidado de la salud. Lo invitamos, **en cualquier momento**, a que nos haga preguntas, informe sobre síntomas, o converse sobre cualquier inquietud que tenga. Si necesita más información sobre su salud o condición, por favor pregunte.

Firma del paciente	Fecha	Firma del médico

COMMUNICATION CONSENT AGREEMENT

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

NAME: _____ RELATIONSHIP _____

ADDRESS: _____

PHONE #: _____ AGE: _____ DOB: _____

DRIVERS LICENSE #: _____ SSN: _____

OTHER FORMS OF ID: _____

NAME: _____ RELATIONSHIP _____

ADDRESS: _____

PHONE #: _____ AGE: _____ DOB: _____

DRIVERS LICENSE #: _____ SSN: _____

OTHER FORMS OF ID: _____

NAME: _____ RELATIONSHIP _____

ADDRESS: _____

PHONE #: _____ AGE: _____ DOB: _____

DRIVERS LICENSE #: _____ SSN: _____

OTHER FORMS OF ID: _____

PATIENT SIGNATURE: _____ DATE: _____

Primaria Medical Clinic

222 W.6th St. Corona, CA. 92882
Tel: (951)278-2530 Fax: (951)278-9746

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

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

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

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

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

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of this Notice Of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason

Primaria Medical Clinic

PRIVACY PRACTICES ACKNOWLEDGEMENT NOTICE

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.

UNDERSTANDING YOUR HEALTH RECORDS/INFORMATION

EACH TIME YOU VISIT A HOSPITAL, PHYSICIAN AND OTHER HEALTHCARE PROVIDERS, A RECORD OY YOUR VISIT IS MADE. TYPICALLY, THIS RECORD CONTAINS YOUR SYMPTOMS, EXAMINATION, TEST RESULTS, DIAGNOSES, TREATMENT AND PLAN FOR FUTURE CARE OR TREATMENT. THIS INFORMATION OFTEN REFERRED TO AS YOUR HEALTH OR MEDICAL RECORD, SERVES AS:

- BASIS OF PLANNING YOUR CARE AND TREATMENT
- MEANS OF COMMUNICATION AMONG THE MANY HEALTH CARE PROFESSIONALS WHO CONTRIBUTE TO YOUR CARE
- LEGAL DOCUMENT DESCRIBING THE CARE YOU RECEIVED
- MEANS BY WHICH YOU OR A THIRD PARTY PAYER CAN VERIFY THAT SERVICES BILLED WERE ACTUALLY PROVIDED
- A TOOL IN EDUCATING HEALTH PROFESSIONALS
- A SOURCE OF DATA FOR FACILITY PLANNING AND MARKETING
- A TOOL WHICH WE CAN ASSESS AND CONTINUALLY WORK TO IMPROVE THE CARE WE RENDER AND THE OUTCOMES WE ACHIEVE.
- UNDERSTANDING WHAT IS IN YOUR RECORD AND HOW YOUR HEALTH INFORMATION IS USED HELPS YOU TO ENSURE ITS ACCURACY, BETTER UNDERSTAND WHO, WHAT, WHEN, WHERE AND WHY OTHERS MAY ACCESS YOUR HEALTH INFORMATION AND MAKE MORE INFORMED DECISIONS WHEN AUTHORIZING DISCLOSURE TO OTHERS.

YOUR HEALTH INFORMATION RIGHT

ALTHOUGH YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF THE HEALTHCARE PRACTITIONER FACILITY THAT COMPILED IT, THE INFORMATION BELONGS TO YOU. YOU HAVE THE RIGHT TO:

- REQUEST A RESTRICTION ON CERTAIN USES AND DISCLOSURES OF YOUR INFORMATION
- OBTAIN A PAPER COPY OF THE NOTICE OF INFORMATION PRACTICES UPON REQUEST
- INSPECT AND OBTAIN A COPY OF YOUR HEALTH RECORD
- AMEND YOUR HEALTH RECORD
- OBTAIN AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH RECORD
- REQUEST COMMUNICATIONS OF YOUR HEALTH INFORMATION BY ALTERNATIVE MEANS OR AT ALTERNATIVE LOCATIONS.
- REVOKE YOUR AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN.

OUR RESPONSIBILITIES

THIS ORGANIZATION IS REQUIRED TO:

- MAINTAIN THE PRIVACY OF YOUR HEALTH INFORMATION
- PROVIDE YOU WITH A NOTICE AS TO OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO INFORMATION WE COLLECT AND MAINTAIN ABOUT YOU
- ABIDE BY THE TERMS OF THIS NOTICE
- NOTIFY IF WE ARE UNABLE TO AGREE TO A REQUESTED RESTRICTION
- ACCOMMODATE REASONABLE REQUESTS YOU MAY HAVE TO COMMUNICATE HEALTH INFORMATION BY ALTERNATIVE MEANS OR AT ALTERNATIVE LOCATION.

WE RESERVED THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL PROTECTED HEALTH INFORMATION WE MAINTAIN. SHOULD OUR INFORMATION PRACTICE CHANGE, WE WILL MAIL A REVISED NOTICE TO THE ADDRESS YOU'VE SUPPLIED US WITH. WE WILL NOT USE OR DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION, EXCEPT AS DESCRIBED IN THIS NOTICE.

Signed_____ Date_____

(Signature of Patient/Parent/Patient's legal Representative)

Primaria Medical Clinic

222 W.6th St. Corona, CA. 92882

Tel: (951)278-2530 Fax: (951)278-9746

Jose Sanchez M.D.
Family Practice

Fatima Magina M.D.
Family Practice

Advanced Health Care Directive

Dear Patient,

As your Physician, we are required to ask any patient over the age of 18, if they have an existing Advanced Health Care Directive, so that we can incorporate the information into your medical records. You are not required to give us this information but we are required to ask. Please complete this form and return it to the receptionist.

Thank you!

Patient Name:_____ SS#:_____

Patient Signature:_____ Date:_____

I decline to answer the question	Yes	No
Do you have an Advanced Health Care Directive?	Yes	No

If yes, please indicate what type of Directive.

- -Durable power of attorney ___
- -California Natural Death Act ___
- -Living Health Care Will ___
- -Other_____

Will you bring a copy of your Directive into our office for your medical chart? Yes No

---

Office Use Only

Type of Health Care Directive Received_____

Date Received:_____

Staff Initials:_____

Primaria Medical Clinic
222 W.6th St. Corona, CA. 92882
Tel: (951)278-2530 Fax: (951)278-9746

CONSENT AND FINANCIAL RESPONSIBILITY

I hereby consent to medical treatment by Jose A. Sanchez, M.D., Fatima C. Magina, M.D.
_____initials

I understand that all fees are due at the time of service unless Jose A. Sanchez, M.D., Fatima C. Magina, M.D. are a contracted provider for my insurance plan, in which case all co-pays, deductibles, and/or patient percentages required by my insurance are due at the time of service. I understand that my medical insurance may not fully pay for my medical bill and I accept full responsibility for all charges that I incur in Jose A. Sanchez, M.D., Fatima C. Magina, M.D.'s care.

_____initials

I understand that I will receive a monthly billing statement for any balance for which I am responsible and that if I fail to pay the "Due From Patient" portion in full by the due date, I will be charged 1.5% interest per month on the unpaid balance.

_____initials

_____ _____
Signature Date

If you wish to have our office bill your insurance company for your incurred charges, you must sign the Assignment of Benefits and Information Release below. This assignment is assumed to apply to all future claims unless you notify us in writing to the contrary.

I hereby authorize my insurance benefits to be paid directly to Jose A. Sanchez, M.D., Fatima C. Magina, M.D., and I accept financial responsibility for any non-covered services. I authorize to release Jose A. Sanchez, M.D., Fatima C. Magina, M.D. any information required to process insurance claims made on my behalf.

_____ _____
Signature Date

If you are signing this agreement as the responsible party for a minor child, please fillout the statement below as indicated.

I, _____, _____, accept full
(Your Name) (Relationship to Patient)

Financial responsibility as described above and consents to medical treatment by to Jose A. Sanchez, M.D., Fatima C. Magina, M.D. For _____, a minor

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: _____
Physician/Healthcare Facility

To release information on _____(Patient's Name)
_____(Patient's DOB) regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To:
_____
Name
_____
Address
_____ _____ _____
City State Zip Code

The medical information/records will be used for the following purpose:
_____

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

[ ] Limited to the following medical information:

_____
_____
_____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____(initial)

Psychiatric/Mental Health _____(initial)

Tests for Antibodies to HIV _____(initial)

HIV Diagnosis/Treatment _____(initial)

Genetic Information _____(initial)

DURATION

This authorization shall be effective immediately and remain in effect until _____
Date

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of patient *or legal/personal representative patient* Relationship *if other than*

_____ _____
Patient's Name (PRINT) Date

_____ _____
Patient's Social Security Number Patient's Date of Birth

_____ _____
Witness name Witness signature