TruCare Health

PATIENT REGISTRATION FORM

Last name:________________________ First name:________________________ MI: ________
DOB: ____/_____/______ Male________ Female ________Social Security #: ________--_______--__________
Address:____ Home Phone: ____________________
City: ____________________ State:________ Zip: _________ Cell Phone: ____________________
Race:______________ Ethnicity:__________________ Work Phone: ____________________
D.L.#: ______________ Sub ethnicity:__________ Language:__________ Do you need a translator? Y N
May we email you information regarding test results, appointments or special instructions? Yes: _____ No: ______
If yes what is your email:____
Marital Status: Single ______ Married ______ Divorced _______Widowed _______

Insurance information

Do you have health insurance? Yes _________ No, I will be paying cash __________

Responsible party:
Name: ____ DOB: _______/_______/____________
Address: ____ Home Phone:____________________
City: ____________________ States: _______ Zip: _________ Cell Phone: ____________________
Social: _____--________--_______ Drivers Lic: ______________ Work Phone: ____________________

Name of Primary insurance:
Primary:____
Subscriber #: ____________________________ Group #:____________________________
Claims address:____

Secondary Insurance (if applicable):
Name of Insurance: ____
Subscriber #: ____________________________ Group #:____________________________
Claims Address:____

Who were you referred by:
Name: ____________________ Address: ________________________ Zip code: __________

Emergency Contact:
Name: ____________________ Address: ________________________ Zip code: __________

Primary contact #: ________________________ Secondary contact #:________________________

Please read and sign below:

I/We do hereby consent to and authorize the performance of a ll treatments, surgery and medical services by the staff of TrueCare Health, which they may seem advisable. I hereby certify that, to the best of my knowledge all statements contained herein are true. I understand I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage.

I further agree to pay legal interest, collection expense and attorney's fees should it become necessary to assign any amount I may owe for collection. I also hereby authorize TruCare Health to relate information requested by my insurance any company and/or it's representative. I fully understand that this agreement and consent will continue until cancelled by me in writing.

AUTHORIZATION IS HEREBY GIVEN TO TRUCARE HEALTH TO RENDER NECESSARY MEDICAL OR SURGICAL TREATMENT TO ANY MINOR OF WHICH I AM THE PARENT OR LEGAL GUARDIAN.

Date: ____________________ Signature: ____

Cancellation and No Show Policy

In order for us to better serve all of our patients; it is essential that we receive at least a 24 hour notice of any change or cancellation of your appointment.

Failure to provide at least a 24 hour notice of cancellation or change of appointment will result in a **no show appointment fee of $68.00** which is required to be paid in full no later than 30 days from the missed appointment.

By signing below I understand the above.

Patient Name: ____

Signature: ____

Date: ____

TruCare Health Insurance and Payment Policy

I understand that if my insurance does not cover a portion of my medical bills and/or I may have a deductible, copay or coinsurance. I am required to pay any portion that my insurance will not cover. This is a contract that I have set up with my insurance company directly. If clarification of coverage is necessary, I understand that it is my responsibility to contact my insurance for details.

I understand any visits I have today or in the future will potentially incur an out of pocket cost to me at which point I will be responsible to pay. If I have a copay, I am required to pay this copay at the time of the visit. If I have a balance due, I will be responsible for setting up a payment plan with TruCare Health staff, if I cannot pay the balance in full at the time of my office visits.

As of ______________ I am fully aware of the above information and will comply with the office policies of paying all copay, coinsurance or deductible which is charged to me by my insurance. If at any time I do not comply with the payment policy I may be unable to receive care in this office until payment are completed.

____

Patient signature Date

____

Guardian Name Guardian Signature

TruCare Health
1234 W. Chapman Ave., Suite 101, Orange, CA 92868
Email: info@trucarehealth.net | Phone: + 714 532 6713 | Fax: + 714 532 1169

TruCare Health

1234 W. Chapman Ave, Ste 101, Orange, CA 92868

Patient Health & Lifestyle Questionnaire

Date: ___________________

Name: ____ Date of Birth: ___/___/___ Gender: __________

Marital Status: ___ Married ___ Single ___Partner ___Divorced ___ Separated ___Widowed

Occupation: _____________________________________ Employment Status: ___Employed ___Retired ___Disabled
If Disabled, for what reason: ____

Preferred Pharmacy: ___________________________ Phone: __________________ Fax: ___________________
Mail Order Pharmacy: __________________________

Medication:	Dose:	How Often:	For What:

Vitamins/Supplements: ____
____

Surgeries: ____
____

Allergies:	What reaction?

Childhood or Adult Diseases: (Check all that apply)

___ Asthma	___ Cancer	___ High Blood Pressure	___ Diabetes
___ Stroke	___ Anxiety	___ Heart Attack	___ Depression
___ Hepatitis	___ Epilepsy	___ Other Heart Problems	___ High Cholesterol
___ Tuberculosis	___ Pneumonia	___ Kidney failure/disorder	___ Stomach Ulcer
___ Skin Disorder	___ Glaucoma	___ Anemia	___ Sleep Apnea
___ Thyroid Disorder	___ Migraines	___ Heart Arrythmia	___ Blood Clots

___ Other serious illness: ____

Family History:

	(if living)		(if deceased)	
	Age	Health	Age @ death	Cause
Father	___	_____	___	_____
Mother	___	_____	___	_____
Brother/Sister	___	_____	___	_____
Brother/Sister	___	_____	___	_____
Husband/Wife	___	_____	___	_____
Son/Daughter	___	_____	___	_____
Son/Daughter	___	_____	___	_____
Other	___	_____	___	_____

Please check if any blood relative has ever had:

___ Cancer Type: _____________ Who: ________
Type: _____________ Who: ________

___ Diabetes Who: _________________

___ Heart Trouble Who: _________________

___ High Blood Pressure Who: _________________

___ Stroke Who: _________________

___ Seizures Who: _________________

___ Mental Illness Who: _________________

___ Suicide Who: _________________

Physical/Mental Health - Have you had any of the following: (Circle each that applies)

General

Unexplained weight changes	YES	NO
Fever or Sweats	YES	NO
Excessive Fatigue	YES	NO
Weakness	YES	NO
Sleeping problems	YES	NO

Skin

Yellow skin	YES	NO
Itching	YES	NO
Rash/Hives	YES	NO
Color changes	YES	NO
Frequent infections	YES	NO
Easy bruising	YES	NO
Scaling	YES	NO

Eyes

Eye disease or injury	YES	NO
Double vision	YES	NO
Wear glasses/contacts	YES	NO
Blurring	YES	NO

Eyes (continued)

Excessive Dryness	YES	NO
Excessive Tearing	YES	NO
Blind spots	YES	NO

Ears

Impaired hearing	YES	NO
Ringing in the ears	YES	NO
Discharge	YES	NO
Pain	YES	NO
Itching	YES	NO

Sinus/Nose

Chronic sinus trouble	YES	NO
Itching nose	YES	NO
Sneezing/runny nose	YES	NO
Nosebleeds	YES	NO

Respiratory

Frequent Cough	YES	NO
Coughing up blood	YES	NO
Wheezing	YES	NO
Difficulty breathing	YES	NO

Cardiovascular

Chest pain/pressure	YES	NO
Swelling in hands/feet/ankles	YES	NO
Shortness of breath walking	YES	NO
Shortness of breath lying down	YES	NO
Fast heart beat	YES	NO
Skipping heart beat	YES	NO
Waking at night smothering	YES	NO
Pain in calves when walking	YES	NO

Gastrointestinal

Tooth/Gum disease	YES	NO
Abdominal pain	YES	NO
Belching/Bloating	YES	NO
Heartburn/indigestion	YES	NO
Difficulty swallowing	YES	NO
Constipation	YES	NO
Diarrhea	YES	NO
Black/tarry stools	YES	NO
Blood in stools	YES	NO
Vomiting/Nausea	YES	NO
Painful bowel movements	YES	NO

Name:_______________________________

Genitourinary

Leaking/loss of urine YES NO
Difficulty urinating YES NO
Painful urination YES NO
Kidney stones YES NO
Blood in urine YES NO
How many times a night do you get up to urinate?
ONE TWO THREE MORE

(MEN ONLY):

Difficult erection YES NO
Difficulty sustaining erection YES NO

Neurological

Frequent Headaches YES NO
Severe Headaches YES NO
Numbness/tingling YES NO
Dizziness/Vertigo YES NO
Fainting/unconsciousness YES NO

Psychiatric

Psychiatric Care in past/now YES NO
Irritability/Anger YES NO
Loss of Desire to enjoy life YES NO
Daily crying/sadness YES NO

Musculoskeletal

Pain in bone YES NO
Pain in joint YES NO
Swelling in joint YES NO
Difficult movement YES NO
Muscle weakness YES NO
Loss of muscle mass YES NO

Hematologic

Slow healing after cuts YES NO
Excessive/Easy bruising YES NO
Abnormal bleeding YES NO

Gynecological (WOMEN ONLY)

Age period started ____ Age menopause ____
How long do your periods last: ____ days
How often do you have periods: every ____ days
Pain with periods YES NO
Date of last period: __________
Number of pregnancies: _______
Number of live births: ______
How many children: ______
Date of Last Mammogram: ______ Last PAP: ______

Date of Birth:____/____/____

Lifestyle Health

Rate your daily stressors on a scale of 1 – 10 (1 being the lowest): ___Family ___Work ___Social ___Financial ___Health ___Other

Do you smoke tobacco? YES NO
How much _____ pack/day
If NO, did you ever smoke YES NO
How much _____ pack/day
Do you chew tobacco? YES NO
Do you drink alcohol? YES NO
How much ___Daily ___Weekly ___Monthly ___Rarely
Do you drink caffeine? YES NO
Circle which: coffee tea soda energy drinks
How much ____ 6 oz cups/day
Do you drink diet drinks? YES NO
How much water do you drink in a day ____ 8oz cups

Physical Activity

On average, how many days/week do you perform physical activity/exercise ____ days/week
How many minutes per day ____ /day
What type of activity: ___ Light – casual walk
___ Moderate – brisk walk
___ Vigorous – jogging/running
Do you use an App/wrist band to log your activity?
YES NO

Nutrition

Do you feel you eat Healthy YES NO
Do you have a specific diet you adhere to?
YES NO
What diet: ___________________________
Do you log your food YES NO

If you could change your lifestyle for the better what would you want to accomplish: (choose all that apply)
___more energy ___sleep better ___less pain
___less illnesses ___less tired ___be more focused
___more resilience to stress ___improve memory
___be happier ___be more motivated
___take less medication ___reduce chronic disease

How ready and willing are you on a scale of 1 – 10 (1 being the lowest) to make lifestyle changes to improve your health? 1 2 3 4 5 6 7 8 9 10

Sign: ______________________________

Lab Facilities

You have the option to select where you would like your lab studies performed. If you are not sure which lab to use please call your insurance company to verify. It is the patient's responsibility to check their insurance to see which lab is covered and which lab is contracted.

Please indicate your choice with an X.

[ ] Physician Immunodiagnostic Lab

[ ] Quest

[ ] Lab Corp.

[ ] I wish for my provider to select the location for my lab studies

[ ] Other: ____

If at any time I wish to change my location of lab studies, I will notify my care provider in writing.

____

____

Patient's Name Date

<u>HIPPA Notice of Privacy Practices</u>

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.

This Notice of Privacy Practices describes how we may use and disclose your protected healthy information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment of the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other required by law.

Treatment

We will use and disclose your PHI to provide, coordinate, or manage you your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. Your PHI may also be provided to a physician to whom you have referred to ensure that the physician has the necessary information to treat you.

Payment

Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations

We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities, training of medial students, licensing, marketing, fundraising activities and conducting or arranging for other business activities for example, we may disclose your PHI to medical school students who see patients in our office. IN addition, we may use a sign in sheet at the registration desk where we will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI as needed, to contact you to remind you of your appointment.

We may disclose your PHI in the following situations without our authorization. These situations include: as Required by Law, Public Health issues as required by law. Communicable Diseases, Health oversight, Abuse or Neglect, Food and Drug Administration requirements. Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity, National Security, Workers' Compensation, Inmates and Required Uses and Discloses. Under the law, we must make disclosures to you when required by compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician o the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your PHI.

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of or use in a civil, criminal, or administrative action or proceeding: and protected health information that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means that you may ask us not to use or disclose any part of your PHI for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described by this Notice of Privacy Practices. Your request must stat the specific restriction requested and to whom you want the restriction to apply.

Your Physician is not required to agree a restriction that you may request. If the physician believes it is in your best interest to permit the use and disclosure of your PHI, then your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e.: electronically).

You may have the right to have your physician and your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided with this notice.

Complaints: you may complain to us or the Secretary of Health Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate you for filing a complaint.**

THIS NOTICE GOES INTO EFFECT ON MAY 1 2017.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties a privacy practices with respect of PHI. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone.

PRINT NAME: ___________________________________DATE:______________________

SIGANTURE: ____