CLINICAS
DEL CAMINO REAL, INCORPORATED

# Patient Registration Form

## Patient Information

| Last Name: | First Name: | Middle: | Nickname: |
|---|---|---|---|
| Social Security Number: | | Date of Birth: / / | |

## Demographics

| Home Address: Apt/Space # | City: | State: | Zip: |
|---|---|---|---|
| Mailing Address: | City: | State: | Zip: |

Marital Status: ☐Single ☐Married ☐Divorced ☐Legally Separated ☐Widowed ☐Interlocutory ☐Domestic Partner ☐Life Partner

| Preferred Language:<br>☐ English ☐ Spanish ☐ Mixteco<br>☐ Other:_____ | Home Phone Number: | Cell Phone Number: | Email Address: |
|---|---|---|---|

Primary Care Provider:

## Person Responsible (*Must be an adult over 18 years old)*

| Last: | First Name: | Middle: | |
|---|---|---|---|
| Date of Birth: / / | Social Security Number: | Relation to Patient: | |
| Home Address: | City: | State: | Zip: |
| Home Phone Number: | Cell Phone Number: | Email Address: | |

## Parent/Legal Guardian Information (if the patient is younger than 18 years of age)

| Father's Name | Father's Date of Birth: | Father's Cell Phone Number: |
|---|---|---|
| Mother's Name | Mother's Date of Birth | Mother's Cell Phone Number: |

## Insurance Information (Please present your insurance card)

Type(s) of Health Care Coverage: ○ Private Insurance ○ Medi-Cal ○ Medicare ○ None ○ Other: _____

| Primary: | ID #: | Group #: |
|---|---|---|
| Policy Holder Name: | | |
| Relationship to Patient: ☐Self ☐Spouse ☐Parent | Date of Birth: | Social Security Number |
| Secondary: | ID #: | Group #: |
| Policy Holder Name: | | |
| Relationship to Patient: ☐Self ☐Spouse ☐Parent | Date of Birth: | Social Security Number |

## Sexual Orientation (Please answer the following questions in order for us to better serve you.)

**Birth Sex:**
☐ Male ☐ Female
☐ Undifferentiated ☐ Unknown

**Gender Identity:**
☐ Male ☐ Female
☐ Male to Female (MTF)/Trans Female/Trans Woman ☐ Female to Male (FTM)/Trans Male/Trans Man
☐ Choose not to disclose
☐ Additional gender category or other, please specify: _____

**Sexual Orientation:**
☐ Choose not to disclose ☐ Heterosexual
☐ Bisexual ☐ Lesbian, Gay, Homosexual
☐ Something else ☐ Don't know

**Preferred Pronoun:**
☐ Asked but unknown ☐ She, Her, Hers ☐ Ze/Hir
☐ Decline to Answer ☐ They, Them, Theirs
☐ He, Him, His ☐ Other: _____

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## Homeless Status (Please answer the following questions in order for us to better serve you.)

1. Please select one of the below options:

☐ Not Homeless ☐ Street ☐ Shelter ☐ Hotel
☐ Doubling up (Living with Friends/Family) ☐ Transitional (Group Home) ☐ Unreported
2. Are you living in Public Housing? ☐Yes ☐No

## Agricultural Status (Please answer the following questions in order for us to better serve you.)

1. In the last 2 yrs., have you or anyone in your family, worked in any type of agriculture (farm work) like: planting, picking, Preparing the soil, packing house, driving a truck for any type of farm work, worked with animals like cows, chickens, etc.? ☐Yes ☐No
2. In the last 2 yrs., have you or anyone in your family established a temporary home in order to work in any type of agriculture (farm work)? ☐Yes ☐No
3. Have you or a member of your family stopped migrating to work in agriculture (farm work) because of a disability or age? ☐Yes ☐No

## Race/Ethnicity

Race (Mark all that are applicable):

☐ American Indian/ Alaskan Native ☐ Native Hawaiian
☐ Asian ☐ Other Pacific Islander
☐ Black/African American ☐ White
☐ More than one race ☐ Unreported/Refused to Report

Ethnicity:

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown/ Not Reported

## Veteran Status

1. Are you a U.S. Veteran? ☐Yes ☐No

## Family Income *(For Reporting Purposes Only)*

Family Size: ○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

Estimated Annual Household Income: $_____

## Pharmacy Information

**Primary Pharmacy**

Pharmacy Name: _____
Address: _____
City:_____ State: _____ Zip Code:_____
Phone Number:_____
Fax Number: _____

**Secondary Pharmacy (if applicable):**

Pharmacy Name: _____
Address: _____
City:_____ State: _____ Zip Code:_____
Phone Number:_____
Fax Number: _____

## Emergency Contact

Emergency Contact Name:_____

Relationship to Patient:_____

Phone Number (different from primary contact number(s) stated on reverse):

## How Did You Hear About Us?

Please mark one of the following

☐ Friend/Family Member ☐ Mailed Advertisement
☐ Website/ Internet ☐ Insurance Referral
☐ Newspaper ☐ Physician Referral (list name):_____
☐ Yellow Pages ☐ Other (please specify):_____
☐ Radio

I hereby consent to any necessary medical or surgical treatment, which may include prescribed medications issued by the provider. I understand that even simple treatments or diagnostic measures have a risk of complications. In such cases, further consultation with the provider may be necessary. Clinicas Del Camino Real, Inc. will make referrals for specialized services we are unable to provide here.

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I understand that I am financially responsible for all charges, whether covered or paid by said insurance. Should Clinicas Del Camino Real, Inc. participate with my insurance plan all co-payments and co-insurance payments are due at the time services are rendered. I hereby assign to Clinicas Del Camino Real, Inc. all insurance benefits to which I am (or my child is) entitled, including but not limited to Medicare, Private Health Insurance, and any other form of coverage paying benefits. I hereby authorize Clinicas Del Camino Real, Inc. to release all necessary information to secure payment.

Date:_____ Name (Print):_____ Signature:_____

CLINICAS
DEL CAMINO REAL, INCORPORATED

# OPTICAL HEALTH QUESTIONNAIRE

Patient's Name: _____ Date of Birth: _____

Welcome to Clinicas del Camino Real, Incorporated Optometry department. Please complete the form below to help us better serve your visual needs.

1. What is the reason for your visit? _____
2. When was your last eye exam? _____ With Dr. _____

3. Do you have any difficulty seeing far? ◯Y◯N
4. Do you have any difficulty seeing up close? ◯Y◯N
5. Do your eyes frequently feel tired? ◯Y◯N
6. Do you get headaches? ◯Y◯N
7. Are your eyes often red? ◯Y◯N
8. Do you see double? ◯Y◯N
9. Do your eyes frequently itch? ◯Y◯N
10. Do you experience pain in or around your eyes? ◯Y◯N
11. Are you very sensitive to light? ◯Y◯N
12. Do you see flashes of light or shadows? ◯Y◯N
13. Have you ever had surgery or injury to your eyes? ◯Y◯N
14. Do you currently wear glasses? ◯Y◯N
15. Do you currently wear contact lenses? ◯Y◯N
16. Are you interested in contact lenses? ◯Y◯N
17. Are you interested in Lasik refractive surgery? ◯Y◯N

## MEDICAL HISTORY

1. Describe your general Health: _____

2. Are you taking any medications? ◯Y◯N If so, please explain:
3. Are you allergic to any medications? ◯Y◯N If so, which ones?
4. Do you smoke? ◯Y◯N If so, how many per day?

5. Are you currently pregnant? ◯Y◯N
6. Are you currently nursing? ◯Y◯N

7. Do YOU have any of the following:

| | |
|---|---|
| Glaucoma | ◯Y◯N |
| High Blood Pressure | ◯Y◯N |
| Heart Disease | ◯Y◯N |
| Diabetes | ◯Y◯N |
| Arthritis | ◯Y◯N |
| Cataracts | ◯Y◯N |
| Sinus Conditions | ◯Y◯N |
| Epilepsy | ◯Y◯N |
| T.B. | ◯Y◯N |
| Hepatitis | ◯Y◯N |
| Thyroid Condition | ◯Y◯N |
| Any Communicable disease | ◯Y◯N |
| Macular degeneration | ◯Y◯N |
| Cancer | ◯Y◯N |

8. Does anyone in your FAMILY (Blood relative) have:

| | | |
|---|---|---|
| Glaucoma | ◯Y◯N | If yes, please explain who? _____ |
| High Blood Pressure | ◯Y◯N | If yes, please explain who? _____ |
| Heart Disease | ◯Y◯N | If yes, please explain who? _____ |
| Diabetes | ◯Y◯N | If yes, please explain who? _____ |
| Arthritis | ◯Y◯N | If yes, please explain who? |
| Cataracts | ◯Y◯N | If yes, please explain who? |
| Blindness | ◯Y◯N | If yes, please explain who? |
| Eye Turn In or Out | ◯Y◯N | If yes, please explain who? _____ |
| Macular Degeneration | ◯Y◯N | If yes, please explain who? _____ |

Comments: _____

X _____ X _____

Patient Signature Date

CLINICAS del Camino Real, Incorporated

OPTOMETRY DEPARTMENT

## INFORMED CONSENT FOR PUPIL DILATION

Dilation of your eyes is extremely important in order to thoroughly examine the back and periphery. Without dilation, the doctor only sees a small portion of the back of the eye. By increasing the pupil size through dilating drops, the doctor can better view the inside of the eye for detection of cataracts, floaters, hypertensive or diabetic retinal changes, and other retinal diseases and abnormalities. Dilation requires 2 or 3 drops in each eye and takes 20 – 30 minutes to dilate your pupils.

The following known risks and complications incident to or reasonably to be anticipated in connection with pupil dilation are:

1. Distance vision might be slightly blurred
2. Near reading vision might be blurred for 3 to 4 hours
3. Sensitivity to light (disposable sunglasses are provided to make you more comfortable)

You may wish to re-schedule the dilation procedure if you are returning to work or would feel more comfortable bringing someone to drive you home.

PLEASE INDICATE YOUR PREFERENCE:

☐ I agree to have my eyes dilated.
☐ I decline having my eyes dilated.

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DEPARTAMENTO DE OPTOMETRÍA

## AVISO DE CONSENTIMIENTO PARA LA DILATACIÓN DE LA PUPILA

La dilatación de la pupila de sus ojos es extremadamente importante para poder examinar completamente la parte de atrás y la parte periferia. Sin la dilatación, el doctor puede ver solamente una pequeña parte de atrás del ojo. Al aumentar el tamaño de la pupila por medio de gotas para dilatación, el doctor puede ver mejor la parte interior del ojo para detectar cataratas, flotantes, o cambios hipertensivos o de retina diabética, y otras anormalidades y enfermedades de la retina. La dilatación requiere de 2 a 3 gotas en cada ojo y se toma de 20 – 30 para dilatarle sus pupilas.

Los siguientes riesgos e incidentes de complicaciones conocidos de o razonablemente anticipados en conexión con la dilatación de las pupilas son:

1. La visión de lejos puede ser un poco borrosa;
2. La visión para leer de cerca puede ser un poco borrosa de aproximadamente 3 a 4 horas;
3. Sensibilidad a la luz (le proporcionamos lentes desechables para el sol para que se sienta más cómodo/a)

Tal vez usted quiera hacer otra cita para el procedimiento de la dilatación de las pupilas si es que usted tiene que regresar al trabajo, o si se siente más confortable trayendo a otra persona para que la lleve de regreso a su casa.

POR FAVOR INDIQUE SU PREFERENCIA:

☐ Estoy de acuerdo que se me haga la dilatación de mis ojos.
☐ Me niego a que se me haga la dilatación de mis ojos.

_____ _____

Signature of patient or parent/legal guardian
Firma del paciente/padre/guardián

Date/Fecha

_____ _____

Signature of witness
Testigo

Date/Fecha

CLINICAS
DEL CAMINO REAL, INCORPORATED

Patient Name: _____

MR #: _____

# Optometry Appointment Policy

Dear Patient:

When you make an appointment with your optometrist, the time is reserved exclusively for you. If you fail to show up, the appointment time is lost. Clinicas del Camino Real, Incorporated has an Optometry Appointment Policy in an effort to ensure access for all our optometry patients. This includes the following:

1. You must cancel or reschedule your optometry appointment at least 24 hours in advance. Without a 24 hour notice, the appointment is considered a failed appointment.

2. If you are late, your appointment may be cancelled and/or rescheduled for another day. If the optometrist's schedule allows, you may wait to be seen as a "walk-in" (patient without an appointment).

3. If you are a new patient, you will receive a phone call to confirm your appointment 1 week before your appointment date. If you are an established patient you will receive a phone call 48 hours before your appointment date. **In order for the appointment to be considered confirmed, you MUST speak to a Clinicas representative directly and confirm that you will be attending.**

   ***IMPORTANT:***

   ***Due to the large number of patients waiting for an optometry appointment, if you fail to confirm that you will be coming to your appointment, your reserved appointment time will be given to another patient. At that time, you will have the following options: (1) be seen as a walk-in (if time optometrist's schedule allows) or (2) reschedule your appointment.***

Your signature confirms that you have read and understand this policy.

| _____ | _____ | _____ |
|---|---|---|
| Signature (*If minor, parent signature*) | Relation to patient | Date |

CLINICAS del Camino Real, Incorporated

# Patient's Learning Needs Assessment

Patient's Name:_____ Date:_____

We would like to know about your learning preferences so we can make sure we are meeting your needs. Your responses are directly responsible for improving these services. Thank you for your time.

1. Circle highest year of school completed:

| N/A | None | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17+ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | (Primary) | | | | | | | (High School) | | | | (College / University) | | | |

2. What language do you prefer to speak?

   ☐ English ☐ Spanish ☐ Other: _____

3. What language do you prefer to read?

   ☐ English ☐ Spanish ☐ Other: _____

4. Which of the following best describes how you read:

   ☐ Like to read & read often ☐ Can read but do not read often

   ☐ Do not like to read ☐ Do not know how to read

5. How do you prefer to learn new things? (check all that apply)

   ☐ Reading (pamphlets, books) ☐ Listening to audio tapes

   ☐ Practicing new skills following a demonstration ☐ Viewing films / videos

   ☐ Attending individual education sessions ☐ Attending group classes

   ☐ Using instructional illustrations, posters, pictures, flip charts

   ☐ Other:_____

6. Do you have any mental, emotional, or physical conditions that may affect the way you learn?

   ☐ No ☐ Yes

CLINICAS
DEL CAMINO REAL, INCORPORATED

Patient's Name_____ Chart #_____
(Nombre del Paciente) (Numero de Expediente)

**Acknowledgement of Receipt of Clinicas Del Camino Real, Inc.'s Privacy Practices Notice and Advance HealthCare Directives information.**

I,_____ have received a copy of Clinicas Del Camino Real, Inc. Privacy Practices Notice and Advance HealthCare Directives information.

_____ _____
Signature Date

**Reconocimiento de Recibo del Aviso de las Practicas de Privacidad y Directivas por Anticipado sobre la Atencion de la Salud de Clinicas Del Camino Real, Inc.**

Yo,_____ reconozco que he recibido una copia del Aviso de las Practicas de Privacidad y Directivas por Anticipado sobre la Atención de la Salud de Clinicas Del Camino Real, Inc.

_____ _____
Firma Fecha

***Staff Use Only / Para Uso de Oficina Solamente:***

If the Privacy Practices Notice and Advance HealthCare Directives information was not given to the patient or the patient's legal representative, please indicate the reason why below:

Right to Amend If you believe health and/or claims record information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form to the clinic's Privacy Officer. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
b) Is not part of the health information that we keep.
c) You would not be permitted to inspect and copy.
d) Is accurate and complete.

If your request is denied, we will send you the reason why in writing within 60 days.

Right to Choose Someone to Act for You You have the right to choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person may exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before any action is taken.

You can change or cancel your request for someone to act for you as long as you can communicate your wishes.

To change the person you want to make your healthcare decisions, you must sign a statement or tell the doctor in charge of your care.

Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures" This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to the Privacy Officer. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Effective January 1, 2011, you have the right to receive an accounting of all disclosures made from Electronic Health Records (EHR) during the three years prior to the request. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information to the Privacy Officer.

Right to Request Confidential Communications You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communication to Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Disaster Relief Situation You have the right and choice to tell us how to share your information during a disaster relief situation. You can tell us what you want us to do, and we will follow your instructions.

Right to a Paper Copy of This Notice You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, Contact the Privacy Officer.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the bottom right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact your nearest Clinicas del Camino Real, Inc. location and ask to speak to the Privacy Officer. You will not be penalized for filing a complaint.

**Clinicas del Camino Real, Inc. El Rio**
221 Ventura Blvd. Suite 126, Oxnard, CA 93036
(805) 436-3444

**Clinicas del Camino Real, Inc., Fillmore**
355 Central Ave., Fillmore, CA 93015
(805) 524-4926

**Clinicas del Camino Real, Inc., Maravilla**
450 W. Clara St., Oxnard, CA 93031
(805) 488-0210

**Clinicas del Camino Real, Inc., Newbury Park**
1000 Newbury Rd. Suite 150, Newbury Park, CA 91320
(805) 498-3640

**Clinicas del Camino Real, Inc., North Oxnard**
1200 N. Ventura Rd. Suite E, Oxnard, CA 93030
(805) 988-0053

**Clinicas del Camino Real, Inc., Ocean View**
4400 Olds Road, Oxnard, CA 93033
(805) 986-5551

**Ojai Valley Community Health Center**
1200 Maricopa Highway, Ojai, CA 93023
(805) 640-8293

**Clinicas del Camino Real, Inc., Oxnard**
650 Meta Street, Oxnard, CA 93030
(805) 487-5351

**Clinicas del Camino Real, Inc., Santa Paula**
500 E. Main Street, Santa Paula, CA 93060
(805) 933-0895

**Clinicas del Camino Real, Inc., Ventura**
200 S. Wells Rd. Suite 100, Ventura, CA 93004
(805) 647-6322

**Clinicas del Camino Real, Inc. Corporate Office**
200 S. Wells Rd. Suite 200, Ventura, CA 93004
(805) 659-1740

**Clinicas del Camino Real, Inc., Simi - Madera**
1424 Madera Rd., Simi Valley, CA 93065
(805) 522-5722

**Clinicas del Camino Real, Inc., Moorpark**
4279 Tierra Rejada, Moorpark, CA 93021
(805) 222-2323

CLINICAS
DEL CAMINO REAL, INCORPORATED

# NOTICE OF PRIVACY PRACTICES

## THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Clinicas del Camino Real, Inc. is committed to providing quality healthcare services to you. An important part of that is protecting your medical information according to applicable law. This notice describes your rights and duties under Federal Law, as well as other pertinent information.

This notice describes the information privacy practices that are followed by our employees, staff and other office personnel.

This notice applies to the information and records we have about your health, health status, and the health care services you receive at this office.

We are required by law to give you this notice. It tells you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

If you have any questions about this notice, please ask to speak to the Privacy Officer at this or any Clinicas del Camino Real, Inc. locations.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff, or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you. You may revoke your *Consent* at any time by giving us written notice.

Different personnel in our office may share information about you for insurance coverage options and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Business Associate We may use or disclose your health information to a business associate that performs a business function on our behalf and requires your health information in order to do so. Such use or disclosure will only occur after performing due diligence to ensure that the business associate is meeting all statutory and contractual requirements. A written contract will be executed with each business associate, and will be reviewed on a yearly basis, to ensure that the business associate is providing adequate protected health information safeguards.

Appointment Reminders We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive notices about treatment alternatives or health-related services. If you advise us in writing (at the address listed on this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures which occurred before that time. If you do revoke your Consent, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operations, and we may therefore choose to discontinue providing you with health care treatment and services.

SPECIAL SITUATIONS We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety We may use and disclose health Information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law We will disclose health information about you when required to do so by federal, state or local law.

Research We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are.

Organ and Tissue Donation If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military. Veterans. National Security and Intelligence If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness

Law Enforcement We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Public Health Risks We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Coroners, Medical Examiners and Funeral Directors We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends We may disclose health Information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object.

For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care.

We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

## OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. We must obtain your Authorization separate from any Consent may have obtained from you. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

We will not use your name and location in any facility directory, as no facility directory exists.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the Authorization and Consent mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed Consent and a special written Authorization that complies with the law governing HIV or substance abuse records.

## YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Federal law provides you several important rights regarding your health information. You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy You have the right to inspect and obtain a copy your health information, such as medical and billing records, in the format you request, that we use to make decisions about your care. You must submit a written request to the Privacy Officer in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

**What happens when someone else makes decisions about my treatment?**

The same rules apply to anyone who makes healthcare decisions on your behalf – a healthcare agent, a surrogate whose name you gave to your doctor, or a person appointed by the court to make decisions for you. All are required to follow your **Health Care Instructions** or, if none, your general wishes about treatment, including stopping treatment. If your treatment wishes are not known, the surrogate must try to determine what is in your best interest.

The people providing your health care must follow the decisions of your agent or surrogate unless a requested treatment would be bad medical practice or ineffective in helping you. If this causes disagreement that cannot be worked out, the provider must make a reasonable effort to find another healthcare provider to take over your treatment.

**Will I still be treated if I don't make an advance directive?**

Absolutely. You will still get medical treatment. We just want you to know that if you become too sick to make decisions, someone else will have to make them for you. Remember that:

• A **Power of Attorney for Health Care** lets you name an agent to make decisions for you. Your agent can make most medical decisions – not just those about life sustaining treatments – when you can't speak for yourself. You can also let your agent make decisions earlier, if you wish.

• You can create an **Individual Healthcare Instruction** by writing down your wishes about health care or by talking with your doctor and asking the doctor to record your wishes in your medical file. If you know when you would or would not want certain types of treatment, an **Instruction** provides a good way to make your wishes clear to your doctor and anyone else who may be involved in deciding about treatment on your behalf.

**How can I get more information about making an advance directive?**

Ask your doctor, nurse, social worker, or healthcare provider to get more information for you. You can have a lawyer write an advance directive for you, or you can complete an advance directive by filling in the blanks on a form.

CLINICAS
DEL CAMINO REAL, INCORPORATED

# YOUR RIGHT TO MAKE DECISIONS ABOUT MEDICALTREATMENT

**This brochure explains your right to make healthcare decisions and how you can plan now for your medical care if you are unable to speak for yourself in the future.**

**A federal law requires us to give you this information. We hope this information will help increase your control over your medical treatment.**

SF900-E

**The right to choose your primary care provider**

As a patient of Clinicas del Camino Real, Incorporated (Clinicas) we will ensure that you have access to quality health care that is appropriate for your specific needs. You are guaranteed the right to choose your Primary Care Provider (PCP). In the event that you are not completely satisfied with your active PCP within Clinicas you have the right to request another PCP. Your request will be reviewed and all feasible attempts will be made to accommodate your request.

**Who decides about my treatment?**

Your doctors will give you information and advice about treatment. You have the right to choose. You can say "Yes" to treatments you want. You can say "No" to any treatment that you don't want – even if the treatment might keep you alive longer.

**How do I know what I want?**

Your doctor must tell you about your medical condition and about what different treatments and pain management alternatives can do for you. Many treatments have "side effects." Your doctor must offer you information about problems that medical treatment is likely to cause you.

Often, more than one treatment might help you – and people have different ideas about which is best. Your doctor can tell you which treatments are available to you, but your doctor can't choose for you. That choice is yours to make and depends on what is important to you.

**Can other people help with my decisions?**

Yes. Patients often turn to their relatives and close friends for help in making medical decisions. These people can help you think about the choices you face. You can ask the doctors and nurses to talk with your relatives and friends. They can ask the doctors and nurses questions for you.

**Can I choose a relative or friend to make healthcare decisions for me?**

Yes. You may tell your doctor that you want someone else to make healthcare decisions for you. Ask the doctor to list that person as your healthcare "surrogate" in your medical record. The surrogate's control over your medical decisions is effective only during treatment for your current illness of injury or, if you are in a medical facility, until you leave the facility.

**What if I become too sick to make my own healthcare decisions?**

If you haven't named a surrogate, your doctor will ask your closest available relative or friend to help decide what is best for you. Most of the time that works. But sometimes everyone doesn't agree about what to do. That's why it is helpful if you can say in advance what you want to happen if you can't speak for yourself.

**Do I have to wait until I am sick to express my wishes about health care?**

No. In fact, it is better to choose before you get very sick or have to go into a hospital, nursing home, or other healthcare facility. You can use an **Advance Health Care Directive** to say *who* you want to speak for you and *what* kind of treatments you want. These documents are called "advance" because you prepare one before healthcare decisions need to be made. They are called “directives” because they state who will speak on your behalf and what should be done.

In California, the part of an advance directive you can use to appoint an agent to make healthcare decisions is called a **Power of Attorney for Health Care**. The part where you can express what you want done is called an **Individual Health Care Instruction.**

**Who can make an advance directive?**

You can if you are 18 years or older and are capable of making your own medical decisions. You do not need a lawyer.

**Who can I name as my agent?**

You can choose an adult relative or any other person you trust to speak for you when medical decisions must be made.

**When does my agent begin making my medical decisions?**

Usually, a healthcare agent will make decisions for you only after you lose the ability make them yourself. But, if you wish, you can state in the **Power of Attorney for Health Care** that you want the agent to begin making decisions immediately.

**How does my agent know what I would want?**

After you choose your agent, talk to that person about what you want. Sometimes treatment decisions are hard to make, and it truly helps if your agent knows what you want. You can also write your wishes down in your advance directive.

**What if I don't want to name an agent?**

You can still write out your wishes in your advance directive, without naming an agent. You can say that you want to have your life continued as long as possible. Or you can say that you would not want treatment to continue your life. Also, you can express your wishes about the use of pain relief or any other type of medical treatment.

Even if you have not filled out a written **Individual Health Care Instruction**, you can discuss your wishes with your doctor, and ask your doctor to list those wishes in your medical record. Or you can discuss your wishes with your family members or friends. But it will probably be easier to follow your wishes if you write them down.

**What if I change my mind?**

You can change or cancel your advance directive as long as you can communicate your wishes. To change the person you want to make your healthcare decisions, you must sign a statement or tell the doctor in charge of your care.

CLINICAS del Camino Real, Incorporated

# FINANCIAL POLICY

**MR#_____**

Thank you for choosing Clinicas del Camino Real, Inc. (CDCR) as your health care provider. We are committed to providing caring and professional health care services to all of our patients. As part of the delivery of services, we have established a financial policy which is designed to clarify payment policies of our practice. The person responsible for payment is required to read and sign this form.

**PAYMENT**

Full payment is due at time of service. We accept cash, checks and credit cards (Visa, Mastercard, Discover, American Express). There is a $50 fee for all returned checks. The adult accompanying a minor (or guardian of the minor) is responsible for full payment.

**SPECIAL PROGRAMS**

You may be enrolled to special programs to assist in lowering cost of services. You will be responsible for payment for any non-covered service.

**INSURANCE**

All patients must provide valid and up-to-date proof of insurance coverage. Please notify us of any changes in insurance coverage prior to time of service.

We participate in most insurances but it is your responsibility to check if we are covered by your specific insurance plan. We will bill your insurance as a courtesy service to you. The person responsible for payment of services will be sent a bill for any remaining balance not paid by the insurance including services denied as not reasonable or necessary or not covered. Your insurance policy is a contract between you and your insurance company so you will have to contact them to dispute any payment denials.

**USUAL AND CUSTOMARY RATES**

We charge clients what is usual and customary for our area. You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates.

**BALANCE POLICY**

A balance statement will be mailed and payment in full is due upon receipt of this statement. Any balances 120 days past due will be referred to a collection agency and/or credit bureau. The Agency will incur interest charges which will be payable to the agency. In cases of divorce or separated parents, it will be the guarantor's responsibility to pay any balances. Clinicas will not participate in disputes between custodial or non-custodial parents.

**APPOINTMENTS**

Help us serve you better by keeping scheduled appointments. If you are unable to keep it, please contact us to reschedule at least 24 hours before your appointment.

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT BENEFITS**

I hereby authorize CDCR, Inc. to release any information necessary to my insurance carriers regarding my treatment and condition that is necessary to determine plan benefits and to process payment for insurance claims. I authorize payment of services directly to CDCR, otherwise payable to me.

I have read, understand and agree with the Financial Policy.

X_____ X_____

PRINTED name of Person responsible for payment

Signature of patient or Person responsible for payment & DATE

CLINICAS
DEL CAMINO REAL, INCORPORATED

Patient Name: _____

MR #: _____

**CONSENT TO RELEASE HEALTH INFORMATION TO INDIVIDUALS/FAMILY MEMBERS**

The state of California mandates that health information be shared only with the patient or the patient's legal representative. In accordance with this law, every employee of Clinicas del Camino Real, Inc. is required to sign a Confidentially Statement on an annual basis indicating that they will keep the health information of every patient in the strictest confidence.

The staff and/ or physicians cannot release health information to family members of patients without permission from the patient or the patient's legal representative.

In order to authorize our providers and personnel to verbally release general health information to individuals/family members, please list the name(s), phone number and relationship of those individuals in the space provided below.

General information excludes the discussion of sexually transmitted diseases, HIV (AIDS Virus) testing and/or results, pregnancy related services, drug and alcohol counseling, and psychiatric / mental health services.

Name:_____ Phone: _____ Relationship:_____

Name:_____ Phone: _____ Relationship:_____

Name:_____ Phone: _____ Relationship:_____

☐ I **do not** authorize Clinicas del Camino Real, Inc. to release any information concerning my health care to any individual.

*I authorize Clinicas del Camino Real, Inc. to verbally release general health information to the above named individual(s). This authorization will supersede any previous authorization(s) to verbally release general health information.*

_____ _____
Signature of patient or legally authorized individual Date

_____ _____
Witness Date

Revised: January 14, 2020

CLINICAS
DEL CAMINO REAL, INCORPORATED

Patient Name: _____

DOB: _____ MR#: _____

# ELECTRONIC COMMUNICATION CONSENT FORM

Clinicas del Camino Real, Inc. (Clinicas) is pleased to provide additional ways to communicate with its patients by providing access to their medical records through the new Patient Portal and/or the Appointment Confirmation System. We will need your consent in order to send you email or text message notifications relating to the patient portal/appointment confirmation system. ***Please note that portal access and appointment confirmation system is not available for patients ages 12-17.***

For each section, please indicate whether you consent or decline:

**PATIENT PORTAL (You will receive e-mail and/or text message notifications)**

| | | | |
|---|---|---|---|
| ☐ | I consent to participate in Patient portal. | ☐ | I decline to participate in Patient portal. |

_____ I want to grant access to the following person to have access to my patient portal.

First/Last Name: _____ Cell Phone: (  ) - _____
DOB: _____ Email: _____
Relationship: _____

**APPOINTMENT CONFIRMATION SYSTEM (You'll receive text message only)**

| | | | |
|---|---|---|---|
| ☐ | I consent to participate in Appointment Confirmation System. | ☐ | I decline to participate in Appointment Confirmation System. |

I understand that I am responsible for informing Clinicas in writing of any changes in cell phone number and email address. I understand that Clinicas del Camino Real, Inc. does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

I understand that text and email messaging is not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text/email may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in text messages may include your first name, date/time of appointments, name of physician, and physician phone number, or other pertinent information.

_____ _____
Patient/Guarantor Signature Date

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*For Office Use Only*

*(Patient Portal Proxy's Only): Proxy name and information must be manually added in Staff Portal in order to send a portal invite. Employee name and date confirms this task has been done.*

_____ _____
*Staff Name* *Date*

Revised 9/5/2019