4617 Freeport Blvd. Ste F., Sacramento, CA 85822 Phone: 916-431-7384 Fax: 916-422-2127

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO TIDS INFORMATION, PLEASE REVIEW IT CAREFULLY

This notice of Privacy Practices describes how we may use and disclose your protected health 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 health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician/provider, our office staff and others outside of our office that are involved in your care and treatment for the purposes 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 use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage 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 protected health information as necessary to a home health agency that provides care to you. For example, your protected health information may be provided to a physician/provider to whom you have been referred to ensure that the physician/provider has the necessary information to diagnose or treat you.

Payment: Your protected health information 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 protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration

desk where you will be asked to sign your name and indicate your physician/provider. We may call you by name in the waiting room when your physician/provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your 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, and Organ Donation: Research: Criminal Activities: Military Activity and National security: Workers' Compensation: Inmates Required Uses and Disclosure: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our 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/provider or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2. Your Rights:

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. 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 protect health information.

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

Your physician/provider is not required to agree to a restriction that you may request. If the physician/provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information 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/provider amend your protected health information. 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 receive an accounting of certain disclosures we have made, if any, of your protected health information.

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

3. Complaints

You may complain to us or the Secretary of Health and 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 against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number

Advance Directives

Advance Directives are written instructions which communicate your wishes about the care and treatment you want if you reach a point where you can no longer make your own health care decisions.

All health care facilities that receive Medicare and Medi-Cal payments must provide patients with written information concerning **1)** their right to accept or refuse treatment and 2) their right to prepare advance directives. The law does not require that you actually have or make an advance directive.

Under California law adult persons with decision-making capabilities have the right to accept or refuse medical treatment or life sustaining procedures. Artificial nutrition and hydration are among the medical procedures you have the right to accept or refuse.

Reason why you may want to prepare an Advance Directive:

- To ensure you receive the care and services you desire.
- To ensure the refusal of treatment at a determined stage if you have previously stated your desires to do so.
- To designate the person, you would like to make decisions on your behalf.
- To ensure that family and friends understand your wishes regarding health care. If you do not make you wishes clear, your family members and friends may not agree about what type of care and treatment you would want. It is possible that your desires will not be carried out, since a conflict may lead to a lengthy court delay.

Being prepared with an Advance Directive, you can say WHAT types of treatment you want, and WHO you want to speak for you.

The Durable Power of Attorney for Health Care

This is a legally binding document that allows the person you choose (the "agent") to make health decisions for you if and when you are no longer able to make such decisions. You should select a person who knows you well, and whom you trust. Your agent may be a relative or a friend, but must not be your attending doctor. The Durable Power of Attorney for Health Care allows your agent to make any and all health care decisions for you once you are no longer able to decide. This includes routine medical decisions, as well as more complicated decisions. Your agent can even decide to withdraw or withhold life-sustaining procedures if you give your agent that authority.

To be valid, the document must be signed by you and witnessed by two qualified adult witnesses.

Those persons not eligible to be witnesses are your doctor, nurse, their employee or any other healthcare professional.

- You DO NOT need a lawyer to fill out a Durable Power of Attorney of Health Care.
- The Durable Power of Attorney for Health Care allows you, in writing, to declare your desire to receive or not receive life-sustaining treatment under certain conditions. You may list any instructions you want pertaining to health care.

The Natural Death Act

This is another type of advance directive most often called a "Declaration." This document DOES NOT require you to appoint an agent to make health care decisions for you The Declaration is for terminally ill patients. While you still have decision making capabilities, you may sign a Declaration which tells your doctors that you do not want any treatment that would prolong the dying process. The Declaration must be followed in these circumstances:

- If you fall into a permanent unconscious state or a terminal condition (certified by two doctors).
- At the time you cannot make your own health care decisions.

Those persons who are witnesses to the signing of the Declaration must meet the same requirements, as those needed for the Durable Power of Attorney for Health Care.

Do I need a special form for this Durable Power of Attorney for Health Care?

YES. Use a **Durable Power of Attorney for Health Care** form, not a plain Durable Power of Attorney. You can ask your physician, nurse, or social worker about this form.

The California Medical Association has printed forms that meet the legal requirements:

California Medical Association
PO Box 7690
San Francisco, CA 94120-7690
415-882-5175 or visit their website at www.cmadocs.org

For more information about Advanced Directives, contact the State Ombudsman (916) 323-6681 or set up a time to speak with your personal physician.

Other Documents

Other documents that help determine your health care desires IF and WHEN you are

unable to make such decisions for yourself:

"DO NOT RESUSCITATE." This form allows your doctor to withhold "resuscitative measures," should that be your desire. This should be signed by you, your doctor, and a surgeon. The law does not require witnesses and notarization. NO ONE CAN MAKE YOU SIGN A "DO NOT RESUSCITATE" ORDER.

"PREFERRED INTENSITE OF CARE." This is a document of your preferences for care under special circumstances. A discussion with your physician and/or legal representative occurs prior to creating this document.

"LIVING WILL." This lists your desires to receive or not receive life-sustaining medical treatment under certain circumstances. A living will is NOT a legally binding agreement, although it is often accepted as an accurate statement of one's wishes.

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HIPAA NOTICE OF PRIVACY PRACTICES AND POLICIES AND ADVANCE DIRECTIVES INFORMATION

We are required by law to maintain the privacy of, and provide individuals with the HIPAA Notice of our Legal Duties and Privacy Practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number 916- 431-7384.

Signature below is only acknowledgement that you have read, understood, and received a copy of the HIPAA policy and Advance Directives information.

Signature: ______________________________ **Date:** ____________

If not signed by patient:

Name of person signing for patient: ______________________________

Relationship to patient: ______________________

CONSENT FOR TREATMENT OF A MINOR

I, ______________________________ the parent/legal guardian of:

Child's Name: ______________________________ DOB: ____________

Child's Name: ______________________________ DOB: ____________

Child's Name: ______________________________ DOB: ____________

Child's Name: ______________________________ DOB: ____________

I authorize: ______________________________
[Person authorized (over 18 years of age) & Relation]
to bring my child/children to Capitol Family Medical Associates to receive all medical care including immunization(s). I understand the above-named party is responsible for informing me of all information related to services received. This authorization remains in effect until written notice is given revoking this consent.

Signature: ______________________________ **Date:** ____________

If not signed by patient:

Name of person signing for patient: ______________________________

Relationship to patient: ______________________________

PLEASE PRINT CLEARLY, FILL ALL BLANKS ***Write N/A if Not Applicable***

Patient Registration

Patients Name:_______________________________________DOB:_______________Age: _______

Patients Social Security Number: _____________________ Sex: □Male□ Female□ Prefer Not to Answer

Address:...

City, State, Zip:____

Home Phone: (___)___-_____ Cell Phone: (___)____-_____ Alternate Phone: (___)___-______

Email: ____

Emergency Contact: _____________________ Phone#: (___)___-_____ Relation: _____________

Preferred Pharmacy: _________________On (cross street): _________Phone#:(_)___-____

NOTE: <u>IF OVER 18 YEARS OF AGE, SKIP TO INSURANCE INFORMATION</u>

Mother's Name: ____DOB: ________________

Driver's License Number: __________________________Social Security Number: _____________

Address: *(if different from above)* ....

Employer: ____Work Phone:(___)_____-_______

Father's Name: ____ **DOB:** _______________

Driver's License Number: ______________________Social Security Number: ___________

Address: *(if different from above)* ____

Employer: ____Work Phone:(__)____-______

Responsible party status: □ Married □ Single □ Divorced □ Widow

Insurance Information: Please provide receptionist with insurance card(s)

□ Medi-Cal □ HMO □ PPO □ Other: ___________

Primary Insurance: _________________________________**ID#**: ____________________________

Subscriber: _________________________ Relation: ___________________Co-payment: $_______

Secondary Insurance: ______________________________**ID#**: ______________________________

Subscriber:________________ Relation:_________________ Co-payment: $_________________

□ I authorize the release of medical information necessary for the completion of insurance forms; I authorize payment directly to Dr. Khaira, M.D. for all medical or surgical benefits otherwise payable to me under the tenns of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature: ____**Date:** _______________

Capitol Family Medical Associates

Patient History Form

(This medical document is strictly confidential and will not be released without your written authorization)

Last Name: ________________________ First Name: _______________________ Middle: ________

Date of Birth: _______________ Birthplace (City, State, Country): _____________________________

Medical History

AIDS/HIV	□YES □NO	Heart Disease	□YES □NO	Migraines	□YES □NO
Anemia	□ YES □NO	Heart Murmur	□YES □NO	Polio	□ YES □NO
Arthritis	□ YES □NO	Hemorrhoids	□YES □NO	Seizures	□YES □NO
Asthma	□YES □NO	Hepatitis	□YES □NO	Stroke	□YES □NO
Bleeding	□YES □NO	Hernia	□YES □NO	Thyroid Disease	□ YES □NO
Cancer	□YES □NO	High Cholesterol	□YES □NO	Tuberculosis	□YES □NO
Depression	□YES □NO	High Blood Pressure	□ YES □NO	Ulcer	□YES □NO
Diabetes	□YES □NO	Kidney Disease	□YES □NO	Venereal Disease	□ YES □NO
Glaucoma	□YES □NO	Low Blood Pressure	□ YES □NO	Other:________________	
Heartburn	□YES □NO	Low Back pain	□YES □NO	Other:________________	

Date of Last: Tetanus Shot: ________________ Sigmoidoscopy/Colonoscopy: ______________

Mammogram: ________________ Pap Smear: ____________________

Previous Surgeries:	Date(s):	Hospital, City, State:

Medications (please include prescriptions, over the counter meds, vitamins, herbal remedies, etc.):

Name:	Dose:	Frequency:

Drug Allergies: ____

Social History

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Alcohol Use: □ Never □ Rarely □ Moderate □ Daily □ Binge

Tobacco Use: □ Never □ Previously, but quit in _____ □ Current Use (packs/day): ________

Drug Use: □ Never □ Previously, but quit in _____ □ Current Use (type/freq): _________

Education: □ High School _____ yrs. □ College _____ yrs. □ Postgraduate ____ yrs.

Current Occupation: _______________________ Prior Occupation: _____________________________

Have you ever experienced physical, emotional, or sexual abuse in your home or relationship? ___________

Please name a unique or interesting fact about yourself: ____

Capitol Family Medical Associates

Family Medical History

□ No Significant Family History is known

Check ALL that apply	Alcohol/Drug Abuse	Asthma	Cancer (type____)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other____	Other____
Mother																	
Father																	
Brother																	
Sister																	
Child																	
MGM																	
MGF																	
PGM																	
PGF																	
Other: ________																	

Vaccinations

Influenza Vaccination (Flu Season Only) □YES □NO

I have received my annual influenza vaccination this season. □YES □NO

Pneumococcal (Pneumonia) Vaccination (within the last 5 years)

Tetanus, Diphtheria, and Pertussis (Whooping Cough) Vaccination □ YES □NO

I have received at least 3 tetanus and diphtheria vaccines in my lifetime, ***and*** *I received my last booster within the last IO years.*

Shingles (Zoster) Vaccination (For ages 60+ years) □YES □NO

Advance Directives

Information regarding advance directives is available for you.

Do you have advance directives? □YES □NO

Would you like information about advance directives? □YES □NO

Patient Signature: ______________________________ **Date:** ______________

Provider Signature: ______________________________ **Date:** ______________

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TB (Tuberculosis) Screening Questionnaire

Today's Date: _______________

Patient Name: ....DOB: ....

Screening questions:	Please circle response:	
1) Have you ever had a skin test for tuberculosis (PPD)? • If yes, when was your most recent test? Date:____________& Result: □ Negative □ Positive* • *If your TB test result was positive, what is the date of your most recent Chest X-ray? Date:__________________ What was the result? ______________________________ • Have you ever been treated for a positive TB test result? □YES □NO If yes, what medication were you given? Dates you were treated: from: ______________to________________	Yes	No
2) Have you ever been exposed to anyone with active Tuberculosis?	Yes	No
3) Have you ever lived or worked in a medical clinic or hospital, a homeless shelter, drug or alcohol detox facility, or jail where you may have had direct contact with anyone infected with Tuberculosis?	Yes	No
4) Have you ever lived or traveled in Africa, Asia, Central America, Mexico, or South America?	Yes	No
5) Are you immunosuppressed? *(HIV infection, organ transplant, alcohol/drug addiction)*	Yes	No
6) Have you had any treatment with chemotherapy or prednisone (cortisone)?	Yes	No
7) Have you ever received the BCG vaccine (vaccine used against Tuberculosis)? If yes, Date:___________________	Yes	No
8) Are you a Foreign-born person from a country with an elevated TB rate? *(Includes any country other than the US, Canada, Australia, New Zealand, or a country in western or northern Europe)*	Yes	No

Provider Review Initials:____________________
Date:____________________

Staying Healthy Assessment

Adult

Patient's Name (first & last) I Date of Birth I ☐ Female. ☐ Male	Today's Date
Person Completing Form *(If patient needs help)* ☐ Family Member ☐ Friend ☐ Other *(Specify)*	Need help with Form? Yes ☐ No ☐
Please answer all the questions on this form as best as can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.	Need Interpreter? ☐Yes ☐No *Clinic Use Only*

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

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

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow Up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental	☐	☐	☐	☐	☐ Patient Declined the SHA
☐ Alcohol, Tobao;o,DrugUse	☐	☐	☐	☐	
☐ Sexual Issues					

PCP's Signature:	Print Name	Date:
PCP's Signature:	Print Name:	Date:
PCP's Slgn3ture:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Adverse Childhood Experience Questionnaire for Adults

California Surgeon General's Clinical Advisory Committee

Our relationships and experiences-even those in childhood-can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

Instructions: Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday. Then, please add up the number of categories of ACEs you experienced and put the *total number* at the bottom.

Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	☐
Did you lose a parent through divorce, abandonment, death, or other reason?	☐
Did you live with anyone who was depressed, mentally ill, or attempted suicide?	☐
Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	☐
Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	☐
Did you live with anyone who went to jail or prison?	☐
Did a parent or adult in your home ever swear at you, insult you, or put you down?	☐
Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	☐
Did you feel that no one in your family loved you or thought you were special?	☐
Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	☐
Your ACE score is the total number of checked responses	

Do you believe that these experiences have affected your health? ○ Not Much ○ Some ○ A Lot

Experiences in childhood are just one part of a person's life story.
There are many ways to heal throughout one's life.

Please let us know if you have questions about privacy or Confidentiality.

5/5/20

Patient Health Questionnaire-2 (PHQ-2)

Name: DOB:

Over the last *2 weeks*, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

For office coding: O____ + ________ + ________ + _____ -

=*Toto/Score* ________

Adapted from the patient health questionnaire (PHO) screeners (www.phgscreeners.com). Accessed October 6, 2016.
See website for additional Information and translations.

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Policy Regarding Financial Responsibility

Providing quality care for our patients is our primary concern. The following is a summary of our financial policy. We would be happy to provide further clarification if necessary. We ask you to read and sign the following acknowledging that you have been advised of your financial responsibilities for medical services provided here at Capitol Family Medical Associates.

We accept most insurance plans; therefore, please provide us with your insurance card. We will let you know if your plan is one for which our doctors/providers are the designated provider. If you wish to be seen here, you are responsible for payment of ALL co-pays and/or deductibles required by your insurance, if any, are due at the time of service.

Please be aware that not all insurance policies cover all conditions and fees. To be fully aware of your schedule of benefits, please read your insurance policy or contact your insurance representative.

Some elective procedures, such as circumcisions, may not be covered by your insurance, or your insurance may only cover part of the charge. Please be aware that you may be responsible for any charges not fully paid by your insurance.

We accept most forms of payment, including cash, credit cards, or checks. If you are not going to be able to attend a scheduled appointment, a 24-hour notice is mandatory. Please be aware that you may be charged for a missed appointment. Three (3) missed appointments may result in discharge from the office.

I have read this financial policy and understand that I have financial responsibility for payment of medical services provided at this office. I hereby assume and guarantee payment of expenses incurred during any visit. Should legal action be required to secure payment, I agree to pay the legal expenses incurred by this office.

Patient Name:...DOB: ....

Signature: ____ **Date:** ___________________

If not signed by patient:

Name of person signing for patient: ____

Relationship to patient: ____________________________________

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Patient Late and Missed Appointment Policy

(Please read carefully.)

- All office visits are by appointment ONLY. We DO NOT accept walk-ins as they interfere with scheduled appointment times.
- We reserve the right to reschedule your appointment if you are more than 15 minutes late for your appointment.

*** We try to see patients at the time that they are scheduled and try to keep the doctors/providers on time. We will try to accommodate late patients if there are openings on the doctor's/provider's schedule but those are not always available. If there are no openings on the same day, we will reschedule you to the next available appointment. ***

- If you need to reschedule your appointment, please give us at least a 24-hour advanced notice so that we can open the appointment for another patient who may need to be seen the same day.
- Our office will allow ONLY Three (3) missed appointments/no-shows within a 12-month period.
- After the 3rd missed appointment, we will have the discretion to discharging you from our clinic and we will notify you by mail. You will have 30 days from that point to find another provider.
- Our office will do reminder calls for appointments but there are times our office may not be able to.

*** Please understand it is still the responsibility of the patient to keep their appointment or contact our office to cancel the appointment. ***

Signature below acknowledges that you have read, understood, and received a copy of the late and missed policy.

Signature: ____ **Date:** __________________

If not signed by patient:

Name of person signing for patient: ____

Relationship to patient: ____________________________________

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Patient Authorization to Release Protected Health Information

Medical Records Release Request

Patient Name: ____DOB: ______________________________

Address: ____

City: ____State: ____________Zip: _________________

I, ____ authorize the use and/or release of my protected health information (medical records) from:

Doctor's Name/ Office/ Hospital: ____

Address: ____

City: ____State: ____________Zip: _________________

To be released to:

Capitol Family Medical Associates
4617 Freeport Blvd. Ste F Sacramento, CA 85822
Phone: 916-431-7384 Fax: 916-422 2127

Purpose or need for disclosure: ____

____

Expiration: This authorization is effective immediately and will remain in effect until ____ year from the date of signature below.

Revocation: This authorization is subject revocation by written notice by the undersigned below. Revocation of this authorization will not affect any action taken in reliance to this authorization before receipt of the revocation notice.

Redisclosure: The request may not lawfully further the protected health information unless another authorization is obtained or required by law.

Signature: I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents with my direction to the health provider. I understand that, by signing this form, I am confirming my authorization that the healthcare provider may use and/or disclose to the person(s) on this form the protected health information described on this form. I understand that I have the right to receive a copy of this authorization.

Signature: ____**Date:** _____________________

If not signed by patient:

Name of person signing for patient: ____

Relationship to patient: _____________________________________

Capitol Family Medical Associates
4617 Freeport Blvd. Ste F., Sacramento, CA 85822
Phone: 916-431-7384 Fax· 916-422-2127

Release of Patient Information

My medical information may be released or discussed with the following person(s) on my behalf:

Name:______________________________ Relationship: ________________

Name:______________________________ Relationship: ___________________

Name:___________________________ Relationship: ___________________

Name:______________________________ Relationship: __________________

If any details, please explain: ____

____

____

____

□ I do not wish for my medical information to be released or discussed with anybody at this time.

Expiration: This authorization is effective immediately and will remain in effect until ____________, or for one year from the date of the signature below.

Revocation: This authorization is subject revocation by written notice by the undersigned below. Revocation of this authorization will not affect any action taken in reliance to this authorization before receipt of the revocation notice.

Redisclosure: The request may not lawfully further the protected health information unless another authorization is obtained or required by law.

Signature: I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents with my direction to the health provider. I understand that, by signing this form, I am confirming my authorization that the healthcare provider may use and/or disclose to the person(s) on this form the protected health information described on this form. I understand that I have the right to receive a copy of this authorization.

Signature: ____**Date:** ____________________

If not signed by patient:

Name of person signing for patient: ____

Relationship to patient: ______________________________________

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Pain Medication & Narcotic Contract

This agreement is between *(please print name:)*______________________________ hereafter referred to as "patient" and Capitol Family Medical Associates doctors/providers/staff. It is agreed that the following narcotics/controlled substances are to be used as part of the patient's treatment for chronic pain. It is noted that these medications may not eliminate a patient's pain but may reduce it and improve what they are able to do each day.

Initial EACH line and then sign on the back.

_____If you are a new patient, the provider will not prescribe the following drugs below without substantial medical documentation (i.e., provider notes, imaging results, blood work, etc.). Even with documentation, it is not guaranteed the medications will be prescribed as the decision will be based upon the provider's judgement of appropriateness. Yon may be asked to submit to a urine drug screen before the medications will be prescribed.

_____Opioids (including but not limited to): Morphine, codeine, oxycodone, hydromorphone, methadone, tramadol, hydrocodone.

_____Benzodiazepines (including but not limited to): Alprazolam, clonazepam, diazepam, lorazepam, temazepam.

_____Hypnotics (including but not limited to): Zolpidem

_____Central Nervous System Stimulants (including but not limited to): Amphetamine, dexmethylphenidate, atomoxetine, methylphenidate

I Understand:

_______Pain medications do not cure pain conditions and they may cause other problems such as sedation, impaired judgement, constipation, and/or addiction.

_______The main goal of pain medication therapy is to help improve my physical and vocational functioning (for example working, going to school, etc.). If functional improvement does not occur, the pain medications or controlled substances may be tapered and discontinued.

_______Pain medication related side effects are increased if alcohol, sleeping pills, muscle relaxants, anti-seizure medications, anti-anxiety medications, certain antidepressants and/or antihistamines are taken along with the pain medications or controlled substances.

_______Any lost prescriptions may result in tapering or discontinuing my medications or controlled substances prescriptions.

________Any forged, sold or abused prescriptions constitute grounds for dismissal from our clinic.

________If I fail to fulfill my responsibilities, as outlined in the next page, my pain regimen may be tapered or discontinued.

I recognize I have the following responsibilities:

______I will take my medications at the dose and frequency prescribed.

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_______I will not increase or change how I take my medications without the approval of my healthcare provider.

______I will only obtain my pain medications from the physicians/providers from Capitol Family Medical Associates.

______I will not obtain medication from any other pliys1crnns/providers in the community and I will inform my provider of all other medications I am taking.

______I will arrange for refills at the prescribed interval ONLY during regular office hours. I will not request prescription refills after clinic hours, during weekends or on holidays.

______I will only use one pharmacy for medications unless otherwise authorized/agreed upon by my provider.

______I will consent to random drug screening to assure I am only taking prescribed drugs. I understand that a drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking. Failure to submit to the testing at the time and date requested by the provider may result in termination of this contact.

______I will not use illegal or street drugs or another person's prescriptions. If! test positive for any illegal or street drugs or any prescription drugs not prescribed to me, this contract may be terminated.

______I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions will not be replaced.

______I will keep medications only for my own use and will not share them with others.

______I will not drive or operate heavy equipment for 7-14 days after initiation of pain medications or any changes in dosing since pain medications may produce drowsiness and impaired judgement. Furthermore, I will not drive when I feel impaired and understand any changes in my medications may increase side effects.

______I will inform my other healthcare providers that I am taking these pain medications and of the existence of this contract. In the event of an emergency, I will provide this same information to emergency department providers.

______I agree to participate in any medical, psychological, or psychiatric assessments recommended by my provider.

Do you use marijuana? ☐ Yes ☐ No

Do you have a marijuana card? ☐ Yes ☐ No

I have given informed consent to understanding the risks and benefits of pain medication therapy and understanding the above outlined terms and conditions for my prescriptions.

My signature below indicates that I have read and fully understand my responsibilities, terms, and conditions of this contract.

Patient Signature: ____ **Date:** ____________________

Provider Signature: ____ **Date:** ____________________

Immunization Registry Notice to Patients and Parents

Immunizations or 'shots' prevent serious diseases. Tuberculosis (TB) screening tests help to determine if.you may have TB infection and can be required for school or work. Keeping track of shots/TB tests you have received can be hard. It's especially hard if more than one doctor gave them. Today, doctors use a secure computer system called an immunization registry. to keep track of shots and TB tests. If you change doctors, your new doctor can use the registry to see the shot/TB test record. It's your right to limit who is able to access your records in the California Immunization Registry (GAIR).

How does a Registry Help You?

- Keeps track of all shots and TB tests (skin tests/chest x-rays), so you don't miss any or get too many
- Sends reminders when you or your child need shots
- Gives you a copy of the shot/TB record from the doctor
- Can show proof about shots/TB tests needed to start child care, school, or a new job

How Does a Registry Help Your Health Care Team?

Doctors, nurses, health plans, and public health agencies use the registry to:

- See which shots/TB tests are needed
- Remind you about shots needed
- Prevent disease in your community
- Help with record-keeping

Can Schools or Other Programs See the Registry?

Yes, but this is limited. Schools, child care, and other agencies allowed under California law may:

- See which shots/TB tests children need
- Make sure children meet requirements for shots and TB tests needed to start child care or school

What Information Can Be Shared in a Registry?

- patient's name, sex, and birth date
- parents' or guardians' names
- limited information to identify patients
- details about a patient's shots/TB tests or medical exemptions

What's entered in the registry is treated like other private medical information. Misuse of the registry can be punished by law. Under California law, only your doctor's office, health plan, or public health department may see your address and phone number. Health officials can also look at the registry to protect public health.

Patient and Parent Rights

It's your legal right to ask your provider:

- to prevent other providers and schools from accessing your (or your child's) registry records
- not to send shot appointment reminders
- for a copy of your or your child's shot/TB test records
- who has seen the records and to change any mistakes

No action is needed to be part of GAIR. Other GAIR providers, schools, and health officials automatically have access to you or your child's records.

If you want to limit who sees your or your child's records:

1. Check with your provider to see if they can lock your records in GAIR
2. If your provider can't, complete a Request to Lock My GAIR Record form at CAIRweb.org/cair-forms.
3. If you change your mind, complete the Request to Unlock My GAIR Record form.
4. Fax printed forms to 1-888-436-8320, or email them to CAIRHelpDesk@cdph.ca.gov.

For more information, contact the GAIR Help Desk at 800-578-7889 or CAIRHelpDesk@cdph.ca.gov California

Name: ______________________________ Date: ______________

CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

1. Purpose. The purpose of this form is to obtain your consent for a telemedicine consultation with a physician. The purpose of this consultation is to assist in the diagnosis or treatment of: ____
2. Nature of Telemedicine Consultation. Telemedicine involves the use of audio, video or other electronic communications to interact with you, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology. Additionally, a physical examination of you may take place and video, audio, and/or photo recordings may be taken.
3. RISKS, BENEFITS AND ALTERNATIVES. The benefits of telemedicine include having access to medical specialists and additional medical information and education without having to travel outside of your local health care community. A potential risk of telemedicine is that because of your specific medical condition, or due to technical problems, a face-to-face consultation still may be necessary after the telemedicine appointment. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative to telemedicine consultation is a face-to-face visit with a physician.
4. MEDICAL INFORMATION AND RECORDS. All laws concerning patient access to medical records and copies of medical records apply to telemedicine. Dissemination of any patient identifiable images or information from the telemedicine consultation to researchers or other entities shall not occur without your consent.
5. CONFIDENTIALITY. All existing confidentiality protections under federal and California law apply to information used or disclosed during your telemedicine consultation.
6. RIGHTS. You may withhold or withdraw your consent to a telemedicine consultation at any time before and/or during the consult without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which

you would otherwise be entitled. If you are a Medi-Cal recipient and receiving teleophthalmology or teledermatology by store and forward, you have the right to an interactive communication with the physician. This communication may occur at the time of your consultation or within 30 days after you receive the results of the consultation.

My health care provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I have read and agreed to a telemedicine consultation.

Signature of Patient or Patient's Representative

Date of Signing

Relationship of Representative to Patient

Name of interpreter / ID#

Signature of Witness (Required if patient unable to sign)

Refusal: I reguse to participate in telemedicine consultation as described above.

Signature