

COACHELLA VALLEY NEPHROLOGY

43576 Washington St., Suite 100 La Quinta, CA 92253
• Phone: (760) 360-4433 • Fax: (442) 300-2356

81719 Doctor Carreon Blvd., Suite A Indio, CA 92201
• Phone: (760) 347-0707 • Fax: (760) 347-3378

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____

Address _____ City _____ ST _____ Zip _____

Home Phone ( ) _____ Cell ( ) _____ M☐ F☐ MSWD

DOB _____ SSN _____ E-Mail Address: _____

Race _____ Ethnicity _____ Language _____

Emergency Contact _____ Relationship _____

Emergency Contact Phone # _____

Pharmacy Name _____ City ___, ST _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____

Relationship to Patient _____ DOB _____ SSN _____

Employer _____ Phone# _____

City _____ State _____ Zip _____

INSURANCE INFROMATION

Primary Insurance _____

Primary Insurance ID No. _____ Group No. _____

Secondary Insurance _____

Secondary Insurance ID No. _____ Group No. _____

ASSIGMENT OF BENEFITS: I hereby authorize my insurance benefits to be paid to the Doctor and I acknowledge that I'm financially responsible for services that are not covered benefits. I authorize my Doctor to release any pertinent information require for the purpose of billing.

SIGNATURE: _____ **DATE**: _____

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HISTORY & PHYSICAL FORM

Complete all of this form. If a section does not apply to you, please address it with an N/A, so we don't assume you've overlooked it.

Patient Name _____ Date _____
Last,First MI

List your Main Complaint(s): _____
Describe your condition (i.e.onset, cause, etc)

_____

_____

List the date and type of diagnostic procedures (i.e.MRI's, CT scans, X-ray's, etc.) you've had, which pertain to the condition you're being evaluated for today:

_____

_____

MEDICAL HISTORY & REVIEW OF SYSTEMS PLEASE CIRCLE ALL THAT APPLY

Do you or have you had any of the following?

Transmissible Disease(s): None Hepatitis A-B-C HIV TB Other _____

Neurological: Headaches Stroke Epilepsy Aneurysm Other _____

Cardiovascular: Chest Pain High Blood Pressure Heart Disease Other _____

Respiratory: Lung Disease Asthma Shortness of Breath Other _____

Are you a smoker? No Yes #of years_____ #of packs per day _____

Gastrointestinal/ Adb. & Pelvis: Ulcer Hernia Hysterectomy Other _____
Musculoskeletal: MSD Arthritis Back or Neck Pain Other _____

Metabolic: Liver Disease Thyroid Disorder Bleeding Disorder Cancer
Diabetes__Meds.___Insulin Other_____
Genito_Urinary: Kidney Disease Painful Urination Freq. Urination Poss.Pregnancy
Sexual Dysfunction
Eye problems: Blindness Cataracts Glaucoma Vision Difficulty

E.N.T: Hearing Loss Deaf Swallowing Problems Nose Bleeds

Psychological: Anxiety Depression Fatigue Nervousness Other _____

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Previous Hospitalization/Surgeries (List Type and Year)

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Medications you are currently taking

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

List Allergies

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Patient Social History

1. Use of alcohol_____Never_____Rarely_____Moderate_____Daily
2. Use of Drugs Type/freq._____Never
3. Sleep Habits_____
4. Exercise Habits_____
5. Diet_____
6. Sexually Related Complaints_____
7. Leisure Activities (Hobbies)_____
8. Stress Level_____

Family Medical History

	Age	Diseases	If deceased, cause of death
Father			
Mother			
Siblings			
Spouse			
Children			

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ACKNOWLEDGEMENT

Physicians Name_____

Address_____

_____

Telephone_____

Patients Name _____

D.O.B___/___/___

Address_____

_____

Telephone_____

_____

ADVANCED DIRECTIVES

This is an acknowledgement that the physicians, or one of his/her staff members, has provided me information concerning Advance Directives.

1. I am age 18 years or older. (Circle one – YES NO)

2. I realize that I have the option of putting together Advanced Directives for my healthcare. My physicians has provided me written information concerning these Advance Directives> I understand that it is my responsibility to provide my doctor(s) with any documents that are Required to carry out my Advance Directives.

3. I am aware that Advance Directives may be any one of the following:
   A. A Durable Power of Attorney for Health Care
   B. The Declaration in the Natural Death Act-Ex A Living Will
   C. I may write down my wishes, on a piece of a paper, so that my family use the document in deciding my medical treatment in the event I am unable to do so.

Patients Signature_____ Date: _____

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Tuberculosis Evaluation Questionnaire

* You (your child) may be at increased risk for TB if you Answer Yes to any of the following questions
* Sus hijos pueden tener un riesgo muy alto de poder contraer "TB" si contestan en forma afirmativa a a cualquiera de estas preguntas.

Name_____ Medical Record#_____
Age_____ DOB_____ DOS _____

1. Have you (has your child) ever had a positive tuberculosis (TB) skin test? If so what date?
¿ Usted (o su hijo/a) recibido a recibido un resultado positivo del examen de tuberculosis?
YES/SI ▯ Date/Fecha: _____ No▯

2. Do you have a family member or close cantact with a history of confirmed or suspected TB?
¿ Existe algun contacto cercano o algun miembro de la familia que haya sido declarado enfermo TB o que se sospeche tener esta enfermedad?
YES/SI ▯ NO▯

3. Where you (was your child) born in or travel to high TB prevalence countries? (Africa, Asia or Latin America)
¿Nacio usted (su hijo/a) fuera de los estados unidos o visita lugares donde hay tuberculosis?
(Africa, Asia, o Latino America).
YES/SI▯ NO▯

4. Do you have any family member or frequent visitors who are from Africa, Asia, or Latin America?
¿ Tiene usted familiares provenientes de Africa, Asia, o Latino America viviendo en su hogar?
YES/SI▯ NO▯

5. Do you (does your child) have any history of confirmed or suspected HIV infection or other problems with their immune system?
¿ Usted (o su hijo/a) a sido diagnosticado/a con algun tipo de infeccion como el sida o con problemas con su sistema immune?
YES/SI▯ NO▯

6. Do you (does your child) live with any individual who is HIV positive?
¿ Usted (o su hijo/a) vive con un individuo que a sido declarado con VIH positivo?
YES/SI ▯ NO ▯

7. Do you (does your child) live in an "out of home" placement facility?
¿ Usted (su hijo/a se encuentra viviendo temporalmente en un hogar o local sostenido por el gobierno o asistencia social)?
YES/SI ▯ NO▯

8. Have you been or (does your child) live with any individual who has been incarcerated in the last 5 years?
¿ Usted (o su hijo/a) vive con alguna persona que estuvo en prision en los ultimos 5 años ?
YES/SI ▯ NO▯

9. Do you (does your child) live among, or are you (is he/she) frequently exposed to individuals who are homeless, migrant farrm workers, users of street drugs or residents in a nursing home?
¿ Usted (o su hijo/a) vive o se asocia frecuenteme con personas que viven en las calles, trabajadores temporales del campo, utilicen drogas ilicitas inyectables o que residan en asilos/hospitales de convalescencia?
YES/SI ▯ NO▯

10. Do you (does your child) consume alcoholic beverage?
¿ Usted (su hijo/a) consume alcohol?
YES/SI ▯ How Much/Cuanto _____ No▯

* A person who is at increased risk for TB should have a yearly TB test
(All children are tested routinely for TB at 4-5 years, 13-16 years, regardless of risk)
- cualquier persona que tiene un alto riesgo de contraer TB debe hacerse el examen de la tuberculosis cada año (se les examina a los de 4 y 5 años y de los 13 a 16 años).

SIGNATURE:_____DATE:_____

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Patient Name:_____ Date of Birth:_____
First Name MI Last Name

ASSIGNMENT OF BENEFITS:

I hereby authorize direct payment of my insurance benefits to CVN/VCMG for services rendered to me. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that CVN/VCMG is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/ CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs are correct. I authorize the release of any of my records that these programs may request. I hereby direct that payment of my authorized benefits be made directly CVN/VCMG or the physicians on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the CVN/VCMG Group Patient Information Privacy Policy. I hereby authorize CVN/VCMG or the physician individually to release any of my medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL,CALL OR EMAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize CVN/VCMG representative or my physician to mail, calls, or e-mail, me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying me CVN/VCMG that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing and treatment as directed by CVN/VCMG physicians or his or her designee.

PATIENT SIGANTURE:_____ **DATE:**_____

GUARANTOR SIGNATURE:_____ **DATE:**_____
(If different from patient)

GUARANTOR NAME (PLEASE PRINT):_____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. I authorize Dr._____to furnish health information as described below on (name of patient):

_____

2. *This authorization is limited to the following type and amount of information:* (use dates where appropriate)

- ☐ All medical information for the last 2 years
- ☐ Immunization Record
- ☐ Medication List
- ☐ Other _____
- ☐ Laboratory results from (date) _____ to (date) _____
- ☐ X-ray and imaging reports from (date) _____ to (date) _____
- ☐ All medical records relating to injury: (date) _____

3. ***I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about treatment for alcohol and drug abuse, and/or behavioral or mental health services.***

4. THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION: _____

Address: _____

_____

5. The recipient may use the medical records and type of information authorized only for the following purposes:
☐Patient access ☐Continuation of care ☐Application for insurance ☐Other _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Services Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.
If I fail to specify an expiration date, event or condition, this authorization will expire in 60 days.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or request copies of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Provider listed above.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

Recipients of outpatient psychotherapy records are required to destroy these records within 60 days unless they are incorporated into the patient's medical record. It is the responsibility of the recipient to follow confidentiality policies and procedures for the maintenance and destruction of protected health information as set forth in A.B.416, 1999 Stat.ch.527, adding Cal. Civil Code 56 et seq.

Coachella Valley Nephrology
43-576 Washington Blvd. #100
La Quinta, CA 92253
Phone:(760) 360-4433
Fax:(760) 347-3378

Patient Name: _____

Med. Rec.#: _____

Date of Birth: _____

PCP: _____

Valley Comprehensive Medical Group

81719 Doctor Carreon Blvd., Suite A Indio, CA 92201
• Phone: (760) 347-0707 • Fax: (760) 347-3378

PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION WITH OTHERS

I hereby grant permission to Valley Comprehensive Medical Group to speak to the following individuals about my health and disclose my health information including billing and insurance. I understand this authorization does not include information regarding HIV, psychiatric, drug and/or alcohol records, which must be authorized on a separate release.

PERMISO PARA DISCTUTIR INFORMACION DE SALUD PROTEGIDA CON OTROS

Autorizo a Valley Comprehensive para hablar a las siguientes personas acerca de mi salud y revelar mi información médica incluyendo facturación y seguros. Entiendo que esta autorización no incluye información sobre VIH, psiquiátricos, drogas o alcohol los registros, que debe ser autorizado en un comunicado separado.

Patient Name/Nombre del Paciente: _____ DOB/FDN: _____

Spouse/Esposo (a): _____ Guardian: _____

Children/Hijos (as): 1. _____ 2. _____

Sibling/Hermanos (as): 1. _____ 2. _____

Caregiver/Cuidador: _____ Friend/Amigo (a): _____

Emergency Contact/Contacto de Emergencia: _____

Other/Otro: _____

You may discuss my (please check all that apply)
Usted puede discutir mi (por favor marque todo lo que aplique)

- ☐ Visit Notes / Notas de Visita
- ☐ Laboratory Results / Resultados de Laboratorio
- ☐ X-rays / Rayos X
- ☐ Report / Informes
- ☐ All Services and Treatment Rendered / Todos los servicios y tratamientos prestados

I understand that I may revoke this authorization at any time in writing.
I understand that I may revoke this authorization at any time in writing.

Patient Signature/Firma: _____ Date/Fecha: _____

Examples of Disclosure for Treatment, Payment and Health Operations

We will use your health information for treatment:

For example: Information obtained by nurse, P.A.-C., Nurse Practitioner, or other member of your health care team will be placed in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations. Ancillary or Specialty care services may be requested by your physician. Those providers will record their care in their records and a copy will be sent to your physician will know how you are responding to treatment.

This office will use your health information for payment and encounter data.

For example: A bill may be sent to you or your insurance company. The information on or accompanying the bill may include information that identifies you as well as your diagnosis, procedures performed and supplies used.

This office will use your health information for regular health operations.

For example: Members of the Utilization Review Committee or Quality Improvement Council may use your information in your health record to asses the care and outcomes in your case. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare services we provide.

Research - This office may disclose information to researchers when their research has Been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Directors - This office may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Patient Education – This office may give your name, phone number, and diagnosis to the Health Education Department who will contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest of you.

Workers Compensation/TPL – This office may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or third party payers or other similar programs established by law.

Public Health – As required by law, this office may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Correctional Institutions – Should you be an inmate of a correctional institution, this office may disclose to that institution or agents thereof health information necessary for your health and health safety or other individuals.

Law Enforcement – This office may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal and State law makes provisions for your health information to be released to an appropriate over site agency, public health authority or attorney to evaluate professional or clinical standards.

Acknowledgement:
I have read and I understand the contents of this "Notice of Health Information Practices". I understand that I can request a copy of this notice at any time.

_____ _____

Patient or Legal Guardian Date

Valley Comprehensive Medical Group
81-719 Dr. Carreon Blvd.
Indio, Ca 92201
760-347-0707

NOTICE OF HEALTH INFORMATION PRACTICES

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

Understanding your Health Record and Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment and a plan for future care or treatment. This information often referred to as your health or medical record serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal documentation describing the care you received
- Means by which you or a third party payer can verify that services billed were actually provided
- A source of information for public health officials charged with improving the health of the nation
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how our health information is used to help you to:

- Ensure its accuracy
- Better understand who, what, when, where and why others may access your health information
- Make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that complied it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosure of your information as provided by 45 CFR 164.524
- Obtain a paper copy of the notice of information practices upon request
- Inspect and obtain a paper copy of your health record as provided for in 45 CFR 164.528
- Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of our health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent the action has already been taken

Provider Responsibilities

This office is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information y alternative means or at alternative locations
- We will not use or disclose your health information without you authorization, except as described in this notice

This office reserves the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change we will post those changes at this office.

For more information or to report a problem:

If you have a question or would like additional information you may contact the Administrator at 760-347-0707. If you believe your privacy rights have been violated you can file a complaint with the Administrator. There will be no retaliation for filing a complaint.

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Información Del Paciente

Apellido _____ Primer Nombre _____ MI_____

Dirección de casa _____ Ciudad_____ ST_____ CP_____

Teléfono de casa:( ) _____ Cel.: ( ) _____ M☐ F☐ CSVD

Fecha de Nacimiento_____ SSN_____ Correo Electrónico: _____

Raza_____ Etnico_____ Lenguaje_____

Contacto de Emergencia _____ Relación_____

Teléfono del contacto de emergencia _____

Nombre de farmacia _____ Ciudad _____ ST_____

PERSONA RESPONSABLE

Nombre del responsable de esta cuenta _____

Relación con el paciente_____ Fecha de nacimiento_____ SSN_____

Empleador _____ Número de teléfono_____

Ciudad_____ Estado_____ CP_____

INFORMACION DEL SEGURO

Seguro Primario: _____

Seguro Primario ID Número: _____ Numero del grupo _____

Seguro Secundario: _____

Seguro Secundario ID Número: _____ Número del grupo_____

ASIGNACION DE BENEFICIOS: Autorizo a mis beneficios de seguro a pagar el Doctor y reconozco que soy financieramente responsable por servicios que no son beneficios cubiertos. Autorizo a mi médico para liberar cualquier información pertinente requerir a efectos de facturación.

FIRMA: _____ **FECHA**:_____