COACHELLA VALLEY
NEPHROLOGY

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

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

Historia Médica: **Si una sección no se aplica a usted, por favor abordarlo con un N/A.**

Nombre del Paciente: _____ Fecha: _____
Apellido, primer nombre, Inicial

Anote su queja principal(s): _____
Describa su condición (es decir, Inicio, Causa, etc.)

_____

_____

Anote la fecha y el tipo de procedimientos de diagnóstico (es decir, MRI's, CT scans, rayos X's, etc.) que corresponden a la condición por la cual está siendo evaluado hoy.

_____

_____

Historia médica & Revisión de sistemas, por favor circule lo que le aplique:
¿Tiene, o ha tenido, cualquiera de los siguientes?

Enfermedades transmisibles: Ninguna Hepatitis A-B-C VIH TB Otro___ _____

Neurológico: Dolor de Cabeza Ataque Cardiaco Epilepsia Aneurisma Otro _____

Cardiovascular: Dolor de Pecho Presión Alta Sanguínea Enfermedad del Corazón Otro _____

Respiratorio: Enfermedad Pulmonar Asma Dificultad para Respirar Otro _____

¿Fumador/a? NO YES ¿Cuantos años?_____ ¿Cuantos Paquetes por día? _____

Gastrointestinal/Abdominal. & Pelvis: Ulcera Hernia Histerectomía Otro__ _____

Músculo Esquelético: MSD Artritis Dolor de Espalda o Cuello Otro_____

Metabólico: Enfermedad del Hígado Enfermedad de Tiroides Trastorno Sanguíneo Cáncer
Diabetes_____ MED_____Insulina_____ Otro_____

Genitourinario: Enfermedad del Riñón dolor al orinar Urinario Frecuente Poss. Embarazo
Disfunción Sexual
Problemas de los ojos: Ceguera Cataratas Glaucoma Problemas de visión

O.N.G: Pérdida de Audición Sangrado de Nariz Mudo Problemas al ingerir Alimentos

Psicológico: Ansiedad Depresión Fatiga Nerviosismo Otro_____

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Hospitalización/Cirugías previas (anote tipo de Cirugía y fecha)

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Medicamentos que Actualmente esta tomando

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Alergias

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Historia Social del paciente

1. Uso de alcohol_____Nunca_____Raramente_____Moderado_____Diariamente_____
2. Uso de Drogas Tipo/frecuente/Nunca_____
3. Hábitos de sueño_____
4. Hábitos de ejercicio_____
5. Dieta_____
6. Quejas relacionadas sexualmente _____
7. Pasatiempos_____
8. Nivel de Stress_____

Historia Médica Familiar

	Edad	Enfermedades	Si fallecido, causa de muerte
Padre			
Madre			
Hermanos/as			
Esposo/a			
Hijos/as			

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Conocimientos

Nombre del Medico_____

Domicilio_____

_____

Telefono_____

Nombre del paciente_____

Fecha de Nacimiento_____

Domicilio_____

_____

Telefono_____

_____

Avanzes Directivas

Este es un reconocimiento que los médicos o uno de los miembros de su personal, me ha dado información sobre las directivas anticipadas.

1. tengo 18 años de edad o mayor de edad SI_ NO_

2. me doy cuenta que tengo la opción de tener avances Directivas para mi salud. Mi médico me ha dado información sobre las directivas anticipadas por escrito, Entiendo que es mi responsabilidad proporcionar mi médico con todos los documentos que son necesaria para llevar a cabo mis instrucciones anticipadas.

3. soy consciente de que las directivas anticipadas pueden ser alguno de los siguientes:
R. una poder notarial duradero para el cuidado de la salud
B. La Declaración en el Acta de Muerte Natural-Ex Testamento en una vida
C. Yo puedo escribir mis deseos, en un pedazo de papel, para que mi familia utilice la documento para decidir mi tratamiento médico en caso de que yo soy incapaz de hacerlo.

Firma del Paciente:_____ Fecha: _____

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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
* Usted o (su hijo/a) pueden tener alto riesgo der 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 contact 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).

Firma: _____Fecha:_____

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Nombre del Paciente:_____ Fecha de Nacimiento:_____

ASIGNACIÓN DE BENEFICIOS:

Autorizo el pago directo de mis beneficios de seguro a CVN/VCMG por los servicios prestados a mí. Entiendo que es mi responsabilidad saber mis beneficios seguros y si están cubiertos los servicios que voy a recibir. Entiendo y acepto que seré responsable de cualquier pago o saldo CVN/VCMG es incapaz de recoger de mi aseguradora por cualquier razón.

MEDICARE/MEDICAID/SEGURO DE CHAMPUS BENEFICIOS:

Certifico que la información dada por mí en la aplicación de pago en estos programas es correcta. Autorizo la liberación de cualquiera de mis archivos que estos programas pueden solicitar. Por la presente ordeno que pago de mis prestaciones autorizados hacer directamente CVN/VCMG o los médicos en mi nombre.

AUTORIZACIÓN A LA INFORMACIÓN PERSONAL NO PÚBLICA DE LIBERACIÓN:

Certifico que he recibido y leído una copia de la CVN/VCMG, grupo de política de privacidad de información de paciente. Por la presente autorizo CVN/VCMG o el médico individualmente a cualquiera de mi médico o incidental información no pública personal que sea necesario para la evaluación médica, tratamiento, consulta o la tramitación de beneficios de seguro.

AUTORIZACIÓN PARA CORREO, LLAMADA O CORREO ELECTRÓNICO:

Certifico que entiendo los riesgos de la privacidad del correo, llamadas telefónicas y correo electrónico. Autorizo a mi médico por correo, llamadas o correo electrónico, con comunicaciones con respecto a mi salud, incluyendo pero no limitado a las cosas tales como recordatorios de citas, arreglos de referencias y resultados de laboratorio o representante CVN/VCMG. Entiendo que tengo el derecho de revocar esta autorización en cualquier momento notificándolo a mí CVN/VCMG ese efecto en la escritura.

LABORATORIO /RAYOS X/ SERVICIO DE DIAGNOSTICOS

Yo entiendo que podría recibir una cuenta separada, si mi salud medica requiere de exámenes lo que incluye Laboratorios, Rayos X y otros servicios médicos. Yo entiendo que financieramente soy responsable de cualquier servicio que no sea cubierto y no sea reembolsado por mi aseguranza por cualquier motivo.

CONSENTIMIENTO DE TRATAMIENTO:

Yo autorizo conscientemente la evaluación, prueba y tratamiento dirigido por VCMG/CVN o lo que se designado del médico.

Firma del Paciente_____ Fecha_____

Firma de Representante_____ Fecha_____

Nombre de Representante (Imprimir) _____ Fecha_____

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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.

Nombre del Paciente: _____FDN_____

Esposo/a: _____

Niño's Hijo/Hija:

1. _____ 2. _____

Guardian: _____

Cuidador: _____

Hermana: _____

Hermano: _____

Amigo/a: _____

Contaco de Emergencia: _____

Otro: _____

Usted puede discutir mi (por favor marque todo lo que aplique)

☐ Notas de visita

☐ Resultados de laboratorio

☐ Rayos X

☐ Informes

☐ Todos los servicios y tratamientos prestados

Entiendo que puedo revocar esta autorización en cualquier momento por escrito.

Firma de Paciente/tutor _____Fecha_____

Nombre de Paciente/tutor (**Por favor imprimir**) _____

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: _____

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.