CHOWCHILLA FAMILY CLINIC

HIPPA – Patient Consent of information

CHOWCHILLA FAMILY CLINIC, in order to comply with the HIPAA Privacy regulation, requires an authorization from the patient before detailed message are left for the patient. This policy is to protect the privacy of the patient and to protect CHOWCHILLA FAMILY CLINIC the physician and staff of from violating the patient's confidentiality. If there is not a signed consent on the file, physician and staff will only leave their name and telephone number on an answering machine, voicemail or with a live person answering the phone requesting the patient to return the call.
By completing the consent below, you are allowing CHOWCHILLA FAMILY CLINIC physicians and its staff to leave a message on an answering machine, voicemail or with a specified individual. You may specify what information is left and with whom by noting the information the bottom of this form. By signing, you are also consenting to the mailing or faxing of any results, requested by you, to your primary care physician or another physician involved in your care.

I give consent to CHOWCHILLA FAMILY CLINIC physicians and staff to leave a message regarding scheduling, treatment, surgery, lab or radiology results, or other information as necessary (check all that apply):

____via text message
____on an answering machine or voicemail at home or cell phone
____on an answering machine or at work
____with_____relationship_____
____with_____relationship_____

____I do not consent to message being left at work, home or with any other person. I wish to be contacted directly.

_____ _____
Patient's Name (Please Print) Date of Birth

_____ _____
Patient's Signature Date

_____ _____
Witness Date

HIPPA- Notice of Privacy Practice Acknowledgement

___I have been provided a copy of CHOWCHILLA FAMILY CLINIC Practice.
___I have declined a copy of CHOWCHILLA FAMILY CLINIC Notice of Privacy Practice.

_____ _____
Patient's Signature Date

PATIENT REGISTRATION/REGISTRACION

DATE (FECHA): _____ MALE: _____ FEMALE: _____

FIRST NAME (NOMBRE): _____ MIDDLE INITIAL: _____

LAST NAME (APELLIDO): _____

ADDRESS (DOMICILIO): _____

CITY (CIUDAD): _____ ZIP CODE (CODIGO POSTAL): _____

TELEPHONE (TELEFONO): _____

SOCIAL SECURITY # (NUMERO DE SEGURO SOCIAL): _____

DATE OF BIRTH (FECHA DE NACIMIENTO): _____

EMERGENCY (TELEFONO DE EMERGENCIAS): _____

CONTACT PERSON: _____ RELATIONSHIP: _____

EMAIL ADDRESS: _____

PHARMACY: _____

WHAT LANGUAGE DOES THE PATIENT SPEAK? _____

RACE: _____ ETHNICITY: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

MEDICARE: _____ MEDI-CAL (STATE): _____ PRIVATE INS: _____ CASH: _____

AUTHORIZATION:

I CONSENT TO PERFORMANCE OF ALL MEDICAL SERVICES BY CHOWCHILLA FAMILY CLINIC AND/OR HIS ASSISTANTS AS DEEMED FIT TODAY AND IN THE FUTURE. THIS FORM WILL BE GOOD UNTIL REVOKED BY ME VERBALLY OR IN WRITING.

I UNDERSTAND THAT REGARDLESS OF MY INSURANCES STATUS I AM RESPONSIBLE FOR MY ACCOUNT FOR SERVICES RENDERED. I HEREBY AUTHORIZE CHOWCHILLA FAMILY CLINIC TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING THIS ILLNESS/ACCIDENT, AND I HAVE IRREVONABLY ASSIGNED TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY MY INSURANCE. ANY CHARGES NOT PAID WITHIN 30 DAYS WILL START ACCRUING INTEREST AT 1.5% MONTHLY. FOR ALL RETURNED CHECKS THERE IS A FEE OF $25.00

NAME IN PRINT: _____

RELATIONSHIP TO PATIENT: SELF: _____ OTHER: _____

SIGNATURE OF RESPONSIBLE PARTY: _____

ADVANCE DIRECTIVE INFORMATION BROCHURE RECEIPT ACKNOWLEDGEMENT

AMRITPAL S. PANNU, M.D.

ACKNOWLEDGMENT FORM :

I HAVE RECEIVED THE ADVANCE DIRECTIVE INFORMATIONAL BROCHURE AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

DATE: _____

PATIENT NAME: _____ PATIENT DOB: _____

PATIENT SIGNATURE: _____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	**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
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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