ANAHEIM MEDICAL GROUP / URGENT CARE

Patient Last Name:_____ Date of Birth:_____

Patient First Name:_____

Patient Middle Initial:_____ Social Security Number_____

Gender: (Select One) MALE FEMALE Race:_____

Address:_____ Apt/Unit:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Emergency Contact:_____
Relationship to Patient:_____
Address:_____ Apt/Unit:_____
City:_____ State:_____ Zip Code:_____
Home Phone:_____ Cell Phone:_____

Primary Insurance:_____
ID#:_____ Group#:_____
Type: HMO PPO MEDICARE MEDI-CAL CALOPTIMA OTHER

By signing this form, you acknowledge that the above information is true and accurate. You also acknowledge that you are under your own will in signing this form and want to receive urgent care services from this urgent care.

Patient Signature (guardian signature if the patient is a minor under 18 years of age)

Sign:_____ Date:_____

PAST MEDICAL HISTORY FORM

Do You Have Any of the Following:

	Yes	No
High Blood Pressure	O	O
Diabetes	O	O
Anemia	O	O
Asthma	O	O
Rheumatism	O	O
Cancer	O	O
Tuberculosis	O	O
Insomnia	O	O

	Yes	No
Heart Problems	O	O
Liver Problems	O	O
Stomach Problems	O	O
Kidney Problems	O	O
Intestine Problems	O	O
Depression	O	O
Anxiety	O	O
Fatigue	O	O

Other: _____

Have you had surgery? If yes, what type and when:

_____

Medical problems within your family? If yes, specify:

_____

Allergies to Medications:

_____

Are you taking any medications? If yes, please list the medications

_____

Do You Have Any of the Following:

	Yes	No
Fever	O	O
Cough	O	O
Vomiting	O	O
Nausea	O	O
Dizziness	O	O
Vision Loss	O	O
Hearing Loss	O	O
Cold	O	O
Sore Throat	O	O

	Yes	No
Diarrhea	O	O
Blood in your stool	O	O
Pain with Urination	O	O
Muscle Pain	O	O
Bone Pain	O	O
Stomach Pain	O	O
Difficulty Breathing	O	O
Palpitations	O	O
Chest Pain	O	O

Other: _____

Name: _____ Signature: _____ Date: _____

Anaheim Medical Group / Cancer Treatment Center
2571 W. La Palma Ave.
Anaheim CA 92801

Authorization and Acknowledgement

These authorizations/acknowledgements cover all services rendered to me, or the patient I am signing for today and all future dates of service. I understand I may revoke this authorization by informing Anaheim Medical Center/Cancer Treatment Center in writing, but if I do revoke this authorization, it will not affect anything prior to the date the revocation is received by Anaheim Medical Center/Cancer Treatment Center. **Initial**_____

Authorization to Release Information to Family/Friends or Others

I have received a copy of the notice of privacy practices. I authorize Anaheim Medical Group/Cancer Treatment Center to release any information regarding my treatment; including lab results, x-rays, and medical records, to the following individuals/entities (Anaheim Medical Center/Cancer Treatment Center may not release information or records to the names individuals entities unless you identify them here):

Name & Relationship to Patient:_____

Name & Relationship to Patient:_____

This form expires in one year from date signed

Anaheim Medical Group/Cancer Treatment Center will use my home phone number and primary address supplied during registration to contact me regarding my treatment; including lab results, x-rays, and medical records. I will ensure this information is up to date at every visit. **Initial**_____

Acknowledgement or Receipt of Notice of Privacy Practices/Authorization to Treat and Bill

I consent to be treated by Anaheim Medical Group/Cancer Treatment Center. If I am not the patient being treated, I am authorized to consent to treatment and billing for the patient identified below. I authorize Anaheim Medical Center/Cancer Treatment Center to bill my insurance for the care I receive and to release any information to the insurance carrier required to process the bill. I authorize payment of medical benefits to Anaheim Medical Center/Cancer Treatment Center or to outside labs as described below, for all services performed and billed by Anaheim Medical Center/Cancer Treatment Center. I understand that I am responsible for all charges for the treatment I receive. I understand that the providers may utilize the Prescription Monitoring Program service at no additional charge to me. NO GUARANTEE: I acknowledge that the practice of medicine is not an exact science and that Anaheim Medical Center/Cancer Treatment Center has made no guarantee or warranties to me as to the result of treatment for the examination. **Initial**_____

As a courtesy, Anaheim Medical Center/Cancer Treatment Center will bill my medical insurance. If I do not provide complete and accurate medical insurance information, I understand Anaheim Medical Center/Cancer Treatment Center may not receive payment from my insurance carrier and I will be entirely responsible for my bill. Even after my medical insurance pays the bill, I may owe payment for services not covered by my medical insurance and I agree to pay these promptly to the urgent care. I understand that the urgent care my send lab specimens to an outside laboratory. I authorize any lab performing services for me to bill my medical insurance for their services. I understand that my medical insurance may not pay for all services provided by the lab and I agree to pay any remaining balance promptly to an outside lab providing services to me. To protect my privacy and prevent fraud, I understand if I cannot provide acceptable photo identification at the time of service, Anaheim Medical Center/Cancer Treatment Center may choose not to bill medical insurance and may decline credit/debit cards as a form of payment. **Initial**_____

I understand that if I fail to pay for services provided to me, the balance owed may be sent to collection and I may incur collection fees of up to 10% in addition to the amount of the services/treatment rendered. I understand that I may contact Anaheim Medical Group/Cancer Treatment Center to work out a payment arrangement that may prevent this additional cost.
Initial_____

Signature:_____ **Today's Date:**_____

Patient Name:_____ **Patient Date of Birth:**_____

Name/Relationship of Patient Representative:_____

SUMMARY OF THE HIPAA PRIVACY RULE

HIPAA is a federal law that gives you the rights over your health information and sets rules and limits on who can look at and receive your health information.

Your Rights

You have the right to:

Ask to see and get a copy of your health records.
Have corrections added to your health information.
Receive a notice that tells you how your health information may be used and shared.
Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
Get a report on when and why your health information was shared for certain purposes.
If you believe your rights are being denied or your health information is not being protected you can:

File a complaint with your provider or health insurer or
File a complaint with the U.S. Government

You also have the right to ask your provider or health insurer questions about your rights. You also can learn more about your rights, including how to file a complaint from the website at: www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

Who Must Follow this Law?

Doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other healthcare providers.
Health insurance companies, HMO's, most employer group health plans.
Certain government programs that pay for healthcare, such as Medicare and Medicaid.

What Information is Protected?

Information your doctors, nurses, and other healthcare providers put in your medical record.
Conversations your doctor has had about your care or treatment with nurses and other healthcare professionals.
Information about you in your health insurer's computer system.
Billing information about you from your clinic/healthcare provider.
Most other health information about you, held by those who must follow this law.

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether bron or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right ti arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

_____
Patient's or Patient Representative's Initials

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____ _____
Physician's or Authorized Representative's Signature (Date)

By: _____
Print Patient's Name

_____
Print or Stamp Name of Physician, Medical Group or Association Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to Patient. Original is to be files in Patient's medical records.

ANAHEIM MEDICAL GROUP

CONSENT FOR MEDICAL TREATMENT
CONSENTIMIENTO PARA TRATAMIENTO MEDICO

I hereby authorize and request Anaheim Medical Group to provide such medical care and administer such diagnosis and/or therapeutic procedures and treatment as in the judgment of the physician in attendance are deemed necessary and advisable.

Por la presente autorizo y solicito a Anaheim Medical Group, que brined dicha atencion medica y adminstre los procedimientos y tratamients diagnosticos y/o terapeuticos que, a jucio del medico que los atenda, se consideres necessaries y aconsejables.

_____ _____

Signature / Firma Date / Fecha

I understand that I am entering into a contractual relation with Anaheim Medical Group, and the physician for the professional care. I further understand that merit less and frivolous claims for medical malpractice have an adverse effect upon the cost of availability of medical care and may result in irreparable harm to the medical provider. As additional consideration for professional care provided to me by Anaheim Medical Group, the physician, I and/or my representative agree not to advance, directly or indirectly, any false, merit less, and/or frivolous claim(s) of medical malpractice against Anaheim Medical Group and the physician.

Entiendo que estoy entablando una relacion contractural con Anaheim Medical Group y el medico para el cuidado professional. Ademas, entiendo que los meritos menores y las reclamaciones frivolas por negligencia medica tienen un efecto adverso sobre el costo de la disponibilidad de atencion medica y pueden ocasionar danos irreparables al proveedor de servicios medicos. Como consideracion adicional por la atencion profesional que me brindo Anaheim Medical Group, el medico, yo y/o mi representate acordamos no presentar, directa o indirectamente; ningum reclamo(s) falso(s) de merito y/o frivolo de negligencia medica contra Anaheim Medical Group y el medico.

_____ _____

Signature / Firma Date / Fecha

By selecting the ACKNOWLEDGEMENT during the registration process for COVID-19 Diagnostic Testing at Anaheim Medical Group/Cancer Treatment Center, I acknowledge and agree that I have read, understand, and agreed to the statements contained within this form. I have been informed about the purpose of the COVID-19 diagnostic test procedure to be performed, potential risks and benefits and associated costs. I have been provided an opportunity to ask questions before proceeding with a COVID-19 diagnostic test and I understand that if I do not wish to continue with the collection, testing, or analysis of a COVID-19 diagnostic test, I may decline to receive continued services. I have read the contents of this form in its entirety and voluntarily consent to undergo diagnostic testing for COVID-19.

_____

Date

_____ _____

First Name Last Name

_____

Signature of staff, resident or resident appointed guardian

COVID-19
ACTIVE SCREENING QUESTIONNAIRE

This will be updated as the CDC and WA State Health Department's information on COVID-19 continues to change.

Your health and well-being are of the upmost importance and we are taking measures to keep the facility/office a safe environment for employees as well as the individuals under our charge and the public. Therefore, anyone coming into the facility/office will be screened and part of our screening process will include taking their temperature and asking the following questions.

1. Within the last 14-days, have you experienced a new cough that you cannot attribute to another health condition?
   - ☐ YES
   - ☐ NO

2. Within the last 14-days, have you experienced new shortness of breath that you cannot attribute to another health condition?
   - ☐ YES
   - ☐ NO

3. Within the last 14-days, have you experienced a new sore throat that you cannot attribute to another health condition?
   - ☐ YES
   - ☐ NO

4. Within the last 14-days, have you experienced new muscle aches that you cannot attribute to another health condition or a specific activity such as physical exercise?
   - ☐ YES
   - ☐ NO

5. Within the last 14-days, have you had a temperature at or above 100.4° or the sense of having a fever?
   - ☐ YES
   - ☐ NO

6. Within the last 14 days, have you had close contact, without the use of appropriate PPE, with someone who is currently sick with suspected or confirmed COVID-19?* *(Note: Close contact is defined as within 6 feet for more than 10 consecutive minutes)*
   - ☐ YES
   - ☐ NO

If the individual answers YES to any of the questions they will not be allowed into the facility/office unless determined otherwise by a designated DOC medical professional.

NAME_____ **DATE**_____

CUESTIONARIO DE PRE-EVALUACION DEL COVID-19

La corte está tomando precauciones y ahora requiere que cada persona que entra a un Tribunal de Justicia complete este cuestionario de pre-evaluación, antes de salir de su casa, cuando tiene que ir a una corte. Este cuestionario es solo para su revisión y autoevaluación, y no necesita imprimirlo o presentarlo a la corte.

Si está asistiendo a una audiencia de corte, el juez le requerirá que certifique que ha revisado este cuestionario de pre-evaluación.

Si responde "Sí" a cualquiera de las siguientes preguntas:

Y es un participante en un caso, contacte al secretario adjunto para el caso.
Y es un miembro del jurado, contacte al secretario adjunto para el caso.
Y es un posible miembro del jurado, comuníquese con la Oficina del Jurado.
Y es un empleado, contacte a su supervisor o juez.

1. ¿Tiene actualmente o ha tenido en los últimos 14 días, uno de los siguientes síntomas?

Fiebre (de 100.4°F o más)	☐ Sí	☐ No
Tos	☐ Sí	☐ No
Dificultad para respirar	☐ Sí	☐ No
Dolores de músculo o cuerpo	☐ Sí	☐ No
Pérdida reciente de gusto u olfato	☐ Sí	☐ No
Náuseas o vómitos	☐ Sí	☐ No
Diarrea	☐ Sí	☐ No
Fatiga, además de otros síntomas	☐ Sí	☐ No
Dolor de cabeza, además de otros síntomas	☐ Sí	☐ No
Dolor de garganta, además de otros síntomas	☐ Sí	☐ No
Congestión o secreción nasal, además de otros síntomas	☐ Sí	☐ No

2. ¿Está usted o un miembro de su hogar en autoaislamiento, esperando los resultados de una prueba para el COVID-19, o se le ha pedido a usted o a un miembro de su hogar que se autoaísle?

☐ Sí ☐ No

3. ¿En las últimas dos semanas, ha recibido usted o alguien en su hogar un resultado positivo para COVID-19 y se le ha informado que debe permanecer en casa?

☐ Sí ☐ No

NOMBRE_____ **FECHA**_____