CHILD HEALTH HISTORY

HISTORY OF PREGNANCY WITH THIS CHILD:

During which month of pregnancy did you first see the doctor?_____Month
How long was your pregnancy? _____Months
Where was baby born? _____
If baby was born at home, were blood tests for newborn screening done? Yes No

Did you have any illnesses or problems? (including sexually transmitted or other communicable diseases)	YES	NO	Did you use any non-prescribed drugs? (tobacco, alcohol, "street drugs:, over-the-counter or home remedies)	YES	NO
Did you take any medications prescribed by your doctor?	YES	NO	Did the baby go home with you from the hospital?	YES	NO
Did you have a difficulty/abnormal delivery/C-section?	YES	NO	Was more than one baby born?	YES	NO
Did the baby have any problems during the 1st week of life?	YES	NO	Did baby receive any shots for Hepatitis B?	YES	NO

CHILD'S HISTORY: Male Female Is this child adopted? YES NO Birth Weight: _____pounds _____ounces Length: _____ inches

Has your child ever had (Please circle Yes or No):

Measles, Chickenpox, Mumps, Rubella	YES	NO	Vomiting after eating, refusal to eat	YES	NO
Tuberculosis or positive TB Test	YES	NO	Muscle, joint or bone problems	YES	NO
Tonsillitis/Sore Throat	YES	NO	Skin problems	YES	NO
Problems with eyes or vision	YES	NO	Headaches or dizziness	YES	NO
Problems with ears or hearing	YES	NO	Convulsions, seizures, epilepsy	YES	NO
Difficulty breathing/snoring at night	YES	NO	Diabetes	YES	NO
Heart problems	YES	NO	Thyroid problems	YES	NO
Asthma, bronchitis, or pneumonia	YES	NO	Allergies	YES	NO
Anemia, bleeding problems, blood transfusions	YES	NO	Problems with development of school performance	YES	NO
Stomachaches	YES	NO	Serious illness or accident	YES	NO
Diarrhea, Soiling self with stool	YES	NO	Surgery or hospitalization	YES	NO
Bladder Kidney Problems, Wetting self or bed	YES	NO	(GIRLS) Has she stared her periods?	YES	NO
Constipation	YES	NO	(GIRLS) Are there problems with her periods?	YES	NO

FAMILY HISTORY: Does mother (M), father (F), brother (B), sister (S), aunt (A), uncle (U), or grandparent (GP) have:

			Which Family Member?				Which Family Member?
YES	NO	Diabetes		YES	NO	High blood pressure	
YES	NO	Epilepsy or convulsions		YES	NO	Bleeding disorder	
YES	NO	Mental retardation		YES	NO	Tuberculosis	
YES	NO	Heart disease		YES	NO	Allergy	
YES	NO	Cancer		YES	NO	Lung or breathing problems	
YES	NO	Kidney or urinary disease		YES	NO	Eye disorder	
YES	NO	Bone or joint problems		YES	NO	Ear disorder	

PARENT INFORMATION:

	Mother:	Father:
Age:	_____	_____
Height:	_____	_____
Occupation:	_____	_____

HOUSEHOLD INFORMATION: Number of people in home _____
Are both parents living in the home? Yes No
Does anyone in the home smoke, or use drugs or alcohol? Yes No
Language spoken in the home: _____
Do you live in a: House Apartment Mobile Home Shelter Homeless

Patient Identification:

Signature: _____ Date: _____

Relationship to Child: _____

Reviewer's
Signature: _____ Date: _____

What Do You Eat? – Food Frequency Questionnaire

(Ages 8-19)

Circle the names of foods you eat often:

Iron/Protein

Chicken/Turkey Beef Ham/Pork Seafood Eggs Tofu
Hot dog Hamburger Fried Chicken Pizza Tacos
Meat/Bean Burrito Pasta Spaghetti with Meatballs
Peanut Peanut Butter Rice Noodle Soup Beans/Lentils
Tortilla White Bread Whole Grain Bread Cereal
Sweet Bread Potato Dark Green Leafy Vegetables

Fruits and Vegetables

Apple Banana Grapes Pear Peach 100% Juice
Strawberry Pineapple Orange Cantaloupe Melon
Bell pepper Chili pepper Tomato Green Salad Cucumber
Mango Broccoli Cabbage Dark Green Leafy Vegetables
Carrot Peas Green Beans Corn Potato Sweet Potato

Snack

Cookies Fruit Pie Donut Candies Chocolate
Chips Cheese Puffs French Fries Mexican Bread
Popcorn Bagels Pretzels Crackers Fruits Vegetables

Drinks

Water 100% Fruit Juice Soda Fruit Flavored Soda
Sports Drinks Energy Drinks Flavored Drinks
Coffee Coffee Drink Tea Sweetened Tea Herbal Tea
Beer Wine Wine Cooler Alcoholic Drink

Calcium

Nonfat Milk 1 % Lowfat Milk 2 % Milk Whole Milk
Lactose Free Milk Cheese Cottage Cheese Yogurt
Milkshake Ice Cream Calcium Fortified Soy/Plant Milk
Calcium Fortified 100% Juice Tofu Tempeh Soy Beans
Green Leafy Vegetables Dried Figs Prunes Orange
Almonds Almond butter Tahini Beans Corn Tortilla

Name: _____ **Age:** _____ **Date of Birth:** _____

Wt: _____ lbs **Ht:** _____ in **BMI:** _____ **BMI %ile:** _____ **Date:** _____

Office use only:

Circle to indicate the topics discussed:

Healthy eating
Regular meals/snacks
Importance of breakfast
Inadequate food supply
Low fat dairy foods
High sugar foods
Other: _____

Iron/Protein

2-3 servings daily
High iron foods
Plant protein sources such as beans, peas, lentils, nuts, etc.
Limit high fat foods

Fruits and Vegetables

2-4 fruits daily or more
3-5 vegetables daily or more
Vitamin C sources
Vitamin A sources

Calcium

3-4 servings dairy foods/day
Nonfat or 1 % milk
Lowfat dairy choices
Low lactose alternative
Calcium fortified foods
Other food sources of calcium

Snacks

High-sugar snacks
High-fat snacks
Fruit/vegetable snacks
Fast foods

Drinks

< 8-12 oz/day 100% juice
6-8 glasses of water (8 ounces each)/day
Sweetened drinks
Alcohol/caffeine

Referred for identified nutrition problem? **Yes** **No**

If yes, where: _____

Provider initials: _____

What Do You Eat? – Youth Nutrition and Activity Assessment
(Ages 8 - 19)

Provide additional information about your food, activity and habits:

Eating Habits

Do you eat or drink the following meals? Circle one answer per meal.

Breakfast	**Always**	**Usually**	**Occasionally**	**Never**
Morning snack	**Always**	**Usually**	**Occasionally**	**Never**
Lunch	**Always**	**Usually**	**Occasionally**	**Never**
Afternoon snack	**Always**	**Usually**	**Occasionally**	**Never**
Dinner	**Always**	**Usually**	**Occasionally**	**Never**
Evening Snack	**Always**	**Usually**	**Occasionally**	**Never**

Exercise/Physical Activity

How many hours a day do you?

- Watch TV _____ hours/day
- Use a smart phone _____ hours/day
- Play video/computer games _____ hours/day
- Use the internet _____ hours/day

Do you participate in physical education classes at school? **Yes** **No**

Circle all that you participate in:

Walking Running Bicycling Swimming
Dance Yoga Martial Arts Rollerblading
Basketball Softball Soccer Volleyball
Other activities or team sports: _____

How often are you physically active?

_____ times/week _____ minutes/day

Weight/Body Image

Circle one. Are you trying to?

Stay the same Lose weight Gain weight Not concerned

Do you eat less to control your weight? **Yes** **No**

Explain: _____

Have you ever made yourself vomit? **Yes** **No**

If yes, how often? _____ When was the last time? _____

Do you ever "binge" eat? **Yes** **No**

If yes, how often? _____ When was the last time? _____

Circle any of the following that you use:

Diet pills Laxatives
Multivitamins Calcium Iron Vitamin D
Protein powder Nutrition supplements Steroids

What, if any, other products do you use?

Explain: _____

Office use only
Complete assessment below using all information provided:

Eating Habits

Overall diet adequate	**Yes**	**No**
3 meals and snacks	**Yes**	**No**
High iron foods	**Yes**	**No**
Calcium foods	**Yes**	**No**
5 or more fruits/vegetables	**Yes**	**No**
Adequate fluids	**Yes**	**No**

Exercise/Physical Activity

Limits use of TV, phone, internet, video or computer games to ≤ 1-2 hours/day **Yes** **No**

Goal set: _____

Engages in physical activity (60 minutes/day or more) **Yes** **No**

Goal set: _____

Referral made **Yes** **No**

Referred to: _____

Weight/Body Image

BMI %ile _____ Date _____

- ☐ ***BMI between 5th and 85th %iles***
- ☐ ***BMI ≤ 5th %ile***
- ☐ ***BMI between 85th and 95th %iles***
- ☐ ***BMI ≥ 95th %ile***

Signs of eating disorder **Yes** **No**

Counseling given **Yes** **No**

Topics: _____

Goal set: _____

Referral made **Yes** **No**

Referred to: _____

Youth Nutrition and Activity Assessment

(Ages 8 - 19)

Provide additional information about your food, activity and habits:

Eating Habits

Do you eat or drink the following meals? Circle one answer per meal.

Breakfast	**Always**	**Usually**	**Occasionally**	**Never**
Morning snack	**Always**	**Usually**	**Occasionally**	**Never**
Lunch	**Always**	**Usually**	**Occasionally**	**Never**
Afternoon snack	**Always**	**Usually**	**Occasionally**	**Never**
Dinner	**Always**	**Usually**	**Occasionally**	**Never**
Evening Snack	**Always**	**Usually**	**Occasionally**	**Never**

Exercise/Physical Activity

How many hours a day do you?

Watch TV	_____ hours/day
Use a smart phone	_____ hours/day
Play video/computer games	_____ hours/day
Use the internet	_____ hours/day

Do you participate in physical education classes at school? **Yes** **No**

Circle all that you participate in:

Walking	Running	Bicycling	Swimming
Dance	Yoga	Martial Arts	Rollerblading
Basketball	Softball	Soccer	Volleyball

Other activities or team sports: _____

How often are you physically active?

_____ times/week _____ minutes/day

Weight/Body Image

Circle one. Are you trying to?

Stay the same Lose weight Gain weight Not concerned

Do you eat less to control your weight? **Yes** **No**

Explain: _____

Have you ever made yourself vomit? **Yes** **No**

If yes, how often? _____ When was the last time? _____

Do you ever "binge" eat? **Yes** **No**

If yes, how often? _____ When was the last time? _____

Circle any of the following that you use:

Diet pills	Laxatives		
Multivitamins	Calcium	Iron	Vitamin D
Protein powder	Nutrition supplements		Steroids

What, if any, other products do you use?

Explain: _____

Office use only

Complete assessment below using all information provided:

Eating Habits

Overall diet adequate	**Yes**	**No**
3 meals and snacks	**Yes**	**No**
High iron foods	**Yes**	**No**
Calcium foods	**Yes**	**No**
5 or more fruits/vegetables	**Yes**	**No**
Adequate fluids	**Yes**	**No**

Exercise/Physical Activity

Limits use of TV, phone, internet, video or computer games to ≤ 1-2 hours/day **Yes** **No**

Goal set: _____

Engages in physical activity (60 minutes/day or more) **Yes** **No**

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Weight/Body Image

BMI %ile _____ Date _____

- ☐ ***BMI between 5th and 85th %iles***
- ☐ ***BMI ≤ 5th %ile***
- ☐ ***BMI between 85th and 95th %iles***
- ☐ ***BMI ≥ 95th %ile***

Signs of eating disorder **Yes** **No**

Counseling given **Yes** **No**

Topics: _____

Goal set: _____

Referral made **Yes** **No**

Referred to: _____

YUCCA FAMILY MEDICAL CARE

Biographical Information Data Sheet

Please complete this form, sign and return it to the receptionist.

Date (Fecha): _____

PATIENT INFORMATION

Last Name (Apellido):_____ First Name (Nombre): _____

Address (Direccion): _____

City, State, Zip (Ciudad, Estdo, Zona Postal): _____

T elephone Number (Telefono) :_____

Date of Birth (Fechade Nacimiento): _____ Social Security# (Numero De Seguro Social): _____

Male (Hombre) Female (Mujer)

Single (Soltera) Married (Casada) Divorced (Divorcado) Minor (Menor)

Employer (Empleador):_____Employer Phone (Empleador Telefono): _____

1. Emergency Contact

Name (Nombre):_____

Relationship to Patient (Relacion con el Paciente):_____

Home Phone (Numero De La Casa): _____ Work (El Trabajo) _____

2. Responsible Party (Persona Responsible)

Name (Nombre): _____

Relationship to Patient (Relacion Con El Paciente):_____

Birthday (Fecha De Nacimiento):_____ Driver's License # (Numero De Licenia)_____

3. Insurance Information Name of Insured (Nombre):

Name of Insurance: _____

Policy#: Group#:_____

4. Advance Directive Do you have Advance Directive? (Tiene usted Advance Directivo?) YES NO
Would you like written information about Advance Directive? (Le gustaria a usted informacion escrita? Sobre el Advance Directivo?) YES NO

5. Authorization and Release (Authorizacion)

I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the attending physician. I hereby authorize the physician to release any information acquired in the course of my examination or treatment. I(patient orguardian) am an eligible member as of the date of service of a health plan and a copy of the benefits card is attached to this document. Signature or the responsible party below acknowledges full financial responsibility of services rendered to me if it is determined Im not eligible on the date of service in question or if service rendered is determined to be a non-covered benefit under the plan provisions. I hereby irrevocably authorize payment directly to the above named corporation, benefits otherwise payable to me but not to exceed the corporation's regular charge due as a result of this claim. I understand i am financially responsible to the corporation for charges not covered.

Patient/Guardian Signature (Firma Del Paciente O Padres Si Es Minor): _____

Date (Fecha): _____

Yucca Family Medical Care
57675 29 Palms Hwy. Ste. #111
Yucca Valley, CA 92284

Patient's Name:_____

Pharmacy Name:_____
Phone Number:_____
Address:_____
_____

RX History Contest: I hereby authorize Pablo Sobero,MD to obtain my previous prescription/medication history through external sources.

Signature:_____

Date:_____

Yucca Family Medical Office Policies

The following policies are standard procedure at Yucca Family Medical Care:

1) All patients are required to understand and know their own medical health insurance plans. Yucca Family Medical Care is not responsible for any treatments or medications that are not covered by your plan. It is the patient's responsibility to contact their own insurance companies to make sure about the coverage they are receiving under their policies.

2) Patients may NOT discuss their medical insurance policy or any political issues related to medical coverage with the providers. Please refer insurance issues with your agent or company that you are covered by. Medical offices are not responsible for knowing your policy.

3) All co-payments are due at the time of patient's appointment. We reserve the right to refuse service if co-payment is not rendered. This office only accepts cash, credit or debit as a form of payment. We do not accept checks for any co-payments at this office. Payments must be rendered before seeing medical provider.

4) All patient bill balances are due within 30 days of receipts of bill. Patient balances that are over 90 days due will be sent to collections, and this office reserves the right to discharge patients with overdue balances.

5) All patients will be charged a minimum of $25.00 for any medical records, medical forms or other forms (i.e DMV forms, school forms, etc.) that require the doctor/medical provider's review and/or signature. This fee is due at the time of submitting forms to our office. Longer and more complex forms will be a higher rate to be determined at the time of review. There are no exceptions to this situation regardless of patient's fiscal situation.

6) Please allow 72 hours for pharmacy refills.

7) No smoking, drinking of beverages of any kind, or eating in the office.

8) Please turn off cell phone during examinations. The doctor/medical provider reserves the right to terminate the examination if patient talks on their cell phone during examination.

9) All triplicate prescriptions will be refilled only at the date that is allowed. Early refills will not be permitted.

10) This office does not have the equipment or storage space to hold patients' x-rays. We receive patient x-ray reports and can interpret results based on the reports we receive. The reports are stored in your patient chart. We suggest that patients retain their own x-rays.

11) Yucca Family Medical Care has a zero tolerance policy against aggressive behavior, unreasonable and/or unrealistic expectations, bullying, profanity, sexual innuendos, written and verbal abuse towards our staff from patients and their family members. Any display of this behavior will be subject to being discharged as a patient from this practice.

12) If a patient transfers to another primary care physician's office for reasons other than reassignment of their insurance plan which this office does not accept or moving to another geographic location away from the Yucca Valley vicinity, we will not allow the privilege of returning as a patient at this office.

13) If a patient is over 15 minutes late the appointment may be rescheduled depending on the schedule for the day.

14) If you feel you have an issue with our operational procedures such as staffing, referrals, etc., it is expected that you notify the office manager prior to contacting the insurance plan. Aggressive and unwarranted complaints will results in you being discharged from the office.

15) This office is not responsible for making appointments for your referrals for other medical providers or support services. It is the responsibility of the patient or his/her medical guardian

Yucca Family Medical Care, Inc.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Yucca Family Medical Care to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Yucca Family Medical Care's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Yucca Family Medical Care reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Yucca Family Medical Care, Privacy Office at 57675 29 Palms Hwy #111 Yucca Valley, CA 92284.

With this consent, Yucca Family Medical Care may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Yucca Family Medical Care may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Yucca Family Medical Care may e-mail my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Yucca Family Medical Care restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Yucca Family Medical Care's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Yucca Family Medical Care, may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Patient Name

_____

Date

NOTICE QF PRIVACY PRACTICES - Effective Date: April 14, 2003
THIS NOTICE DESCRIBES HOINFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEÀSE REVIEW IT CAREFULLY.

Your Health Information Rights - Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information, however, we are not required to agree to your request for restrictions.
- Inspect and obtain a paper copy of your health records, except in limited circumstances upon written request, a fee will be charged to copy your record. If you are denied access to your health record for certain reasons, we will tell you why and what your rights are to challenge that denial.
- Amend your health record. Your request must be in writing and state a reason. If we deny your request, we will tell you why and what your rights are to challenge flat denial. Even if we accept your request, we will not delete any information already in our records. You have the right to add an addendum (up to 250 words) to your health record.
- Obtain an accounting of disclosures of your health information for purpose other than treatment, payment or health care operations, disclosures to you or authorized by you, incidental disclosures and certain other excluded disclosures. Your request must be in writing.
- Request confidential communications of your health information by alternative means or at alternative locations
- Revoke authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities -This organization is required to:

- maintain the privacy of your health information provide you with à 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 currently in effect notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information confidentially by alternative means or at alternative locations. Contact the Correspondence Desk to make this request.
- not use or disclose your health information without your authorization, except as described in this notice

Examples of Disclosure for Treatment, Payment and Health Care Operations

- *We will use and disclose your health information for treatment.*

For example: Information obtained by a nurse, physician, or other member of your healthcare team will recorded in your record. Your physician will document in your record his or her expectations. We may disclose your health information to ancillary or specialty care services that may be requested by your physician for treatment. Those providers will record their care in their records and copy your physician on their observations. In that way, you will be provided treatment and your physician will know how you are responding to treatment.

- *We will use and disclose your health information for payment/encounter data.*

For examples A bill may be sent to you or a third party payer or HMO. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used and your treatment for which payment is requested. We may also disclose your heath information for one of your other health care providers to submit requests for payment.

- *We will use and disclose your health information for our health care operations.*

For example: Members of the medical staff and the risk or quality improvement team of this practice may use information in your health record to assess 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.

- *We will use and disclose your health information for health care operations of others.*

For example: We may disclose your health information to other health care providers or payors for their health care operations only if they already have a relationship with you and the purpose is for quality assurance activities, peer review activities, detecting fraud, or other limited purposes.

EXAMPLES:

Involvement in your care: We may disclose information to individuals involved in you care or to individuals who pay or help pay for your care.

Abuse, neglect or domestic violence: We may disclose information for reporting abuse, neglect or domestic violence to a government authority; including a social service or protective services agency as authorized by law.

Health oversight activities: We may disclose health information to a health oversight agency for oversight activities authorized by law.

Judicial and administrative proceedings: We may disclose health information in the course of any judicial or administrative proceeding.

Serious threat to health or safety: We may disclose health information to prevent a serious threat to the health or safety of another.

Specialized government functions: We may disclose health information required by command authorities for military and Veterans.

National Security and intelligence activities: We may disclose health information for National Security and intelligence activities,

Genetic Testing Information: If we keep genetic testing information about you, we will release that information only to the state departments that monitor our work or if required by law to release that information. Otherwise, we will give out this information only if you give us your permission in writing,

Communicable Disease Information: If you have a communicable disease, such as HIV/AIDS, we will provide that information to your health care provider, to providers engaged in: organ procurement, or if required by law. For all other purposes, we will give out this information only with your permission....

Research: We 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: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Patient Education: We may contact you to provide appointment reminder or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Workers Compensation/Third Party Liability: We 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, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease; injury, or disability:

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health safety of other individuals.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law We reserve 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 the medical facility and on the Website: www.myDOHC.com

For More Information, Report a Problem, or exercise your rights -You may contact: Customer Service Manager at (760) 320-5134, Ext. 1302, there will be no retaliation for filing a complaint. You may also contact the Secretary of the Deparment of Health and Human Services, Office of Civil Rights. San Francisco Office, U.S. Department of Education, Old Federal Building, 50 United Nations, San Francisco, CA, 94102-4102.

I acknowledge that I have received this Notice of Privacy Practices Patient Responsible Party

_____ Date_____

☐ Patient ☐ Responsible Party Signature

DHCS

DHCS Telehealth Policy Implementation
Patient Consent –Model Language

Written Consent Communication

1. I agree to receive health care services via telehealth. I understand that:
    a. I have the right to access Medi-Cal covered services through an in-person, face-to-face visit or through telehealth.
    b. The use of telehealth is voluntary, and I may withdraw my consent to, or stop receiving services through telehealth at any time without affecting my ability to access covered services in the future.
    c. Medi-Cal provides coverage for transportation services to in-person services when other resources have been reasonably exhausted.
    d. There may be limitations or risks related to receiving services through telehealth as compared to an in-person visit. For example_____.
2. I have read this document carefully, understand the potential limitations and risks of receiving services via telehealth, and have had my questions answered to my satisfaction.

Verbal Consent Communication

"Under Medi-Cal you have the option to receive services in person in a face-to-face visit or via telehealth. If you have trouble accessing in person services due to transportation, Medi-Cal provides coverage for transportation services when other resources have been reasonably exhausted. There may be limitations or risks related to receiving services through telehealth rather than in person. For example_____. If you choose to receive services by telehealth, you may change your mind at any time by letting us know. If you change your mind about using telehealth, you will still have access to Medi-Cal covered services..
Knowing all of this, do you want to have the option of receiving services from us now or in the future via telehealth? (Yes/No)."

Yucca Family Medical Care

57675 29 Palms Hwy. Ste. #111 Yucca Valley, CA 92284

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I authorize _____

(name of physician of healthcare provider to use or disclose information)

To furnish to Yucca Family Medical Care Fax # 760-365-8599

(Name and address of person/organization to which disclosure is made)

Health information described below on: _____

(Patient Name)

For the purpose of: _____

This information is limited to the following type and amount of information. (Use dates where appropriate).

__ Progress Notes
__ Consultation Reports
__ Laboratory/Pathology Reports
__ Radiology/Imaging Reports
__ Medical Records relating to injury
__ Immunization Records

__ Any and all records for last 2years

Specific Date From_____ to_____
__Other_____
_____

DISCLOSURE REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release at any time. I understand that my revocation must be in writing and presented to the Health Information Management 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 consent a claim under my policy. Unless otherwise revoked, this authorization will expire on the following dates event or condition:

_____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on providing or refusing this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the Director of Health Information. I understand I have a right to receive a copy of this authorization.

_____
Signature of Patient, Parent or Legal guardian

_____
Patient Date of Birth

_____
If signed by other than patient, indicate authority to sign

_____
Patient Address

_____
Patient telephone number

_____
Patient Social Security Number

_____
Witness signature

_____
Date