"STAYING HEALTHY" ASSESSMENT
Adults, 18 years of age and older

Patient Stamp

Patient Number | Plan Name/Number

If patient stamp not used, write in Patient and Plan Name/Number

Patient's name (first, last)	Date of birth	Sex ❐ Male ❐ Female	Today's date	***For Clinical Use*** **Assistance needed:** **Reading:** ❐ Yes ❐ No **Interpreter:** ❐ Yes ❐ No

Annual Review Date/Initials

You and your health care team can work together towards better health. Please answer these questions as best you can. You may check (✔) "Skip" if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your medical record.

Sample Question and Answer: Do you play sports? ✔ Yes | No | Skip

Interventions Code/Date/Initials

Do You:

#	Question			
1.	Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?	No	Yes	Skip
2.	See the dentist at least once a year?	Yes	No	Skip
3.	Drink milk or eat yogurt or cheese at least 3 times each day?	Yes	No	Skip
4.	Eat fruits and vegetables every day?	Yes	No	Skip
5.	Try to limit the amount of fried or fast foods that you eat?	Yes	No	Skip
6.	Exercise or do moderate physical activity such as walking or gardening 5 days a week?	Yes	No	Skip
7.	Think you need to lose or gain weight?	No	Yes	Skip
8.	Often feel sad, down, or hopeless?	No	Yes	Skip
9.	Have friends or family members that smoke in your home?	No	Yes	Skip
10.	Often spend time outdoors without sunscreen or other protection such as a hat or shirt?	No	Yes	Skip

For Clinical Use

Intervention Codes: **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

Continue →

Your answers to questions about alcohol and drug use cannot be released to others without your special written permission.

For Clinical Use

Interventions Code/Date/Initials

Do You:

11. Smoke cigarettes or cigars or use any other kinds of tobacco? No Yes Skip

12. Use any drugs or medicines to go to sleep, relax, calm down, feel better, or lose weight? No Yes Skip

13. Often have more than 2 drinks containing alcohol in one day? No Yes Skip

14. Think you or your partner could be pregnant? No Yes Skip

15. Think you or your partner could have a sexually transmitted disease? No Yes Skip

Have You:

16. Or your partner(s) had sex without using birth control in the last year? No Yes Skip

17. Or your partner(s) had sex with other people in the past year? No Yes Skip

18. Or your partner(s) had sex without a condom in the past year? No Yes Skip

19. Ever been forced or pressured to have sex? No Yes Skip

20. Ever been hit, slapped, kicked, or physically hurt by someone? No Yes Skip

21. **Do you have other questions or concerns about your health?** No Yes Skip

(Please identify) ____________________

____

____

____

For Clinical Use

Intervention Codes: **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

Privacy Statement

The Information Practices Act of 1977 (California Civil Code 1798) and the Federal Privacy Act (5 USC 552a. Subdivision (E)(3)) require this notice to be provided when collecting personal information from individuals. The information on this form is requested by your health care provider, health plan, and the Department of Health Services for purposes of providing health education services. Furnishing the information requested on this form is optional for the patient. Failure to provide the information requested will not result in any negative consequence for the patient. Information collected on this form is to be maintained in the patient's medical record, and is subject to the same medical and legal protection as other information maintained in the patient's medical record. State law and regulation including reporting requirements and protection of patient confidentiality applies to all information identified on this form. Within the constraints of these laws and regulations, certain information collected on this form may be transferred to state and local governmental and regulating agencies, contracted health plans, and health care providers.

PATIENT REGISTRATION FORM/FORMA de REGISTRACIÓN del PACIENTE

PATIENT INFORMATION / INFORMACIÓN DEL PACIENTE

Name: (Nombre) Last (Apellido)	First (Primer Nombre)	Middle (Segundo Nombre)

Address: (Dirección) Street (Calle)	City (Ciudad)	State (Estado)	Zip Code (Zona Postal)

Date of Birth (Fecha de nacimiento): / /	Social Security Number: (Número de Seguro Social)	Birthplace: City State/Country (Lugar de nacimiento: Ciudad Estado/Pais)

Sex (Sexo):	Marital Status (Estado Civil):	
☐ Female (Mujer)	☐ Single w/partner (Soltero(a) sin pareja)	☐ Single w/o partner (Soltero (a) con pareja)
☐ Male (Hombre)	☐ Married (Casado(a))	☐ Separated (Separado(a))
	☐ Divorced (Divorciado(a))	☐ Widowed (Viuda(o))

Telephone Number: (Número de Teléfono):	Home: (Casa) ( ) -	Work: (Trabajo) ( ) -	Pager/ Cell Phone: (Teléfono celular) ( ) -
Okay to leave message? (Podemos llamar?)	☐ Yes (Sí) ☐ No	☐ Yes (Sí) ☐ No	☐ Yes (Sí) ☐ No

Email address (Dirección de Correo Electronic):

Mother's Maiden Name: (Apellido Materno)	*Name of Employer: (Nombre del Empleador (si trabaja))*	*Driver's License Number: (Número de Licencia de Manejar)*

IS PATIENT HISPANIC? *(¿ES EL PACIENTE HISPANO?)* ☐ Yes *(Sí)* ☐ No

TRANSLATOR NEEDED *(TRADUCTOR NECESARIO)* ☐ Yes *(Sí)* ☐ No

RACE:
(RAZA)
- ☐ American Indian or Alaska Native *(Indio Americano o Nativo de Alaska)*
- ☐ Asian *(Asiática)*
- ☐ Native Hawaiian *(Nativo de Hawai)*
- ☐ Black or African American *(Negra o Africano Americano)*
- ☐ White *(Blanca)*
- ☐ Hispanic *(Hispano)*
- ☐ Other *(Otro)*
- ☐ Undeclared *(No declarado)*
- ☐ Other Pacific Islander *(Otra Isleña del Pacífico)*

EMPLOYMENT STATUS:
(ESTADO DE EMPLEO)
- ☐ Full Time *(Tiempo completo)*
- ☐ Part Time *(Tiempo parcial)*
- ☐ Not Employed *(Sin empleo)*
- ☐ Self Employed *(Trabajan por cuenta propia)*
- ☐ Retired *(Jubilados)*
- ☐ Active Military Duty *(Servicio militar activo)*
- ☐ Unknown *(Desconocido)*

PRIMARY LANGUAGE:
(LENGUAGE PRIMARIO)
- ☐ English *(Inglés)*
- ☐ Spanish *(Español)*
- ☐ Chinese *(Chino)*
- ☐ Thai *(Tailandes)*
- ☐ Japanese *(Japonés)*
- ☐ Vietnamese *(Vietnamitas)*
- ☐ Korean *(Corea)*
- ☐ Sign Language *(Lenguaje por señas)*
- ☐ Other: ____________ *(Otro)*
- ☐ Cambodian *(Camboyano)*
- ☐ Hmong *(Hmong)*
- ☐ Armenian *(Armenio)*
- ☐ Russian *(Rusia)*
- ☐ Tagalog *(Tagalo)*
- ☐ Laotian *(Laos)*
- ☐ Portuguese *(Portugués)*

STUDENT STATUS: *(ESTUDIANTE DE ESTADO)* ☐ Full Time *(Tiempo Completo)* ☐ Part Time *(Tiempo Parcial)* ☐ Not a Student *(No es un estudiante)*

Present Living Situation

Is Patient Homeless? *(Esta Paciente esta Sin Hogar)* ☐ Yes *(Sí)* ☐ No

If Yes, Where Did Patient Stay Last Night? *(Si Conteso Si, Donde Paso La Noche)*

☐ Homeless Shelter *(Refugio)* ☐ Transitional Shelter *(En transición)* ☐ Doubling Up *(Duplicar hasta)* ☐ Street/Car *(Calle/Coche)* ☐ Other *(Otro)* ☐ Unknown *(Desconocido)*

Emergency Contact (not your own phone number)

(Contacto en caso de emergencia (teléfono que no sea el suyo))

Name: *(Nombre)*	**Last** *(Apellido)*	**First** *(Primer Nombre)*	**Middle** *(Segundo Nombre)*	Relationship *(Relación)*:
Address: *(Dirección)*	Street *(Calle)*	City *(Ciudad)*	State *(Estado)*	Zip Code *(Zona Postal)*
Telephone Number: *(Número de Teléfono)*:	Home: *(Casa)* ( ) -		Work: *(Trabajo)* ( ) -	

HEALTH COVERAGE / COBERTURA DE SALUD

Do you have any type of Medical Insurance? ☐ Yes *(Sí)* ☐ No
(Tiene alguna aseguranza medica?)

If Yes, what type? ☐ Medi-Cal ☐ Medicare ☐ Private Ins.: ________________ ☐ Other: ____________

Do you receive any government assistance, i.e. GR, AFDC? ☐ Yes *(Sí)* ☐ No
(Recibe alguna ayuda del gobierno (ejemplo: GR, AFDC)?)

Are you under the family planning program, Family PACT? ☐ Yes *(Sí)* ☐ No
(Esta bajo algún programa de planificación familiar de Family PACT?)

Household Monthly Income (Gross Income – before taxes): ____________________
(Ingreso Mensual de la Familia: (antes del impuesto))

Household Monthly Income (Net Income – after taxes): ____________________
(Ingreso Mensual de la Familia: (despues del impuesto))

Family Size (Number): ____________________
(Número de miembros en la Familia)

Type of Income Verification *(Tipo de Verificación)*:

☐ Work Check Stub *(Talón de Cheque del Trabajo)*

☐ Oral / Written Verification from employer *(Verificación de su Empleador, Oral o Escrita)*

☐ Unemployment Compensation Award *(Compensación por Desempleo)*

☐ Social Security Check Stub *(Seguridad Social talón de Cheque)*

☐ W-2 or Income Tax Form *(Forma W-2 ó Impuesto de Ingresos)*

☐ Patient was informed to bring *(Informamos al Paciente que Traiga sus Documentos)*

Responsible Party (Parent, Guardian, Spouse/Partner, Authorized Representative)
(Persona Responsable (Pariente, Guardian, Representante Autorizado))

Name: (*Nombre*) **Last** (*Apellido*) **First** (*Primer Nombre*) **Middle** (*Segundo Nombre*)		Relationship (*Relación*):
Address: (*Dirección*) Street (*Calle*) City (*Ciudad*) State (*Estado*) Zip Code (*Zona Postal*)		
Date of Birth (*Fecha de nacimiento*): / /	Social Security Number: (*Número de Seguro Social*)	Driver's License Number: (*Número de Licencia de Manejar*)
Telephone Number: (*Número de Teléfono*): Home: (*Casa*) ( ) -	Work: (*Trabajo*) ( ) -	Pager/ Cell Phone: (*Teléfono celular*) ( ) -

OTHER INFORMATION / OTRA INFORMACIÓN

Referral Source (Check all that apply) *(Referido(a) por (marque todas las que se aplican))*

☐ Friend *(Amistades)*
☐ Family/Relatives *(Familiar/Relativos)*
☐ Newspaper *(Periódico)*
☐ Media *(Los Medios de Comunicación)*
☐ Website *(Página Web)*
☐ Health Fair *(Feria de Salud)*
☐ Health Educators *(Eductores de Salud)*
☐ Outreach *(Información en la Comunidad)*
☐ Other *(Otro)* : ____________________________

Do you have an Advance Directive? *(Usted ha ejecutado una Directiva Anticipada de Salud?)* ☐ Yes (*Sí*) ☐ No
If yes, please provide a copy. *(Si es sí, por favor de proveer una copia.)*
If no, information given. *(Si es no, información dada.)* ________ (Staff Initials)

I certify that the above information is true and accurate to the best of my knowledge. I understand that this verification is made so that T.H.E. Clinic, Inc. can determine my eligibility for payment of medical procedures and/or laboratory services based on the established criteria in the clinic. If any information I have given proves to be untrue, I understand that T.H.E. Clinic, Inc. may reevaluate my financial status and if I have already received services, I am obligated to pay the cost rendered.

Authorization for Assignment for Benefits I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits directly to T.H.E. Clinic, Inc. for services rendered as described on the claim. I acknowledge full responsibility for these charges and agree to pay in full for any and all additional costs including any portion not covered by my insurance coverage.

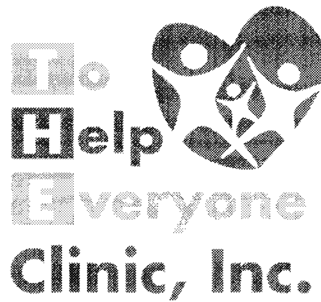
Declaro que toda la información es verdadera y exacta en lo mejor de mi entendimiento. Entiendo que esta verificación es hecha para que la Clínica T.H.E. Inc., pueda determinar mi elegibilidad de pago por los tratamientos médicos y servicios de laboratorio basados en los criterios establecidos en la clínica. Si se prueba que alguna información que he dado es falsa, comprendo que la clínica T.H.E. Inc., puede reevaluar mi estado financiero y si he recibido servicios, estoy obligago/a a pagar el costo requerido.

Autorización para asignación de beneficio *Yo autorizo la revelación ú otra información médica necesaria para procesar éste reclamo. También autorizo los pagos de beneficios médicos directamente a la clínica T.H.E. por los servicios descritos en éste reclamo. Yo reconozco la responsabilidad completa de éstos cargos y consiento pagar por el costo completo y cualquier costo adicional incluyendo cualquier porción que no este cubierta por mi aseguranza.*

____ ________________________

Signature of Patient or Legal Representative
(Firma del Paciente ó Representante Legal)

Date
(Fecha)



CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

Patient Name *(first, middle, last name)*	Date of Birth

I understand that as part of my healthcare, T.H.E. Clinic, Inc., originates and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communications among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer "insurance company" can make sure that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competency of healthcare professionals

I understand and have been provided with a "Notice of Health Information Practices" that explain in more detail the specific use and disclosures of my health information. I understand that I have the right to review this notice prior to signing this consent. I understand that T.H.E. Clinic reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to require restrictions as to how my health information may be used of disclosed to carry out treatment, payment or healthcare operations and that T.H.E. Clinic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that T.H.E. Clinic has already taken action in reliance thereon.

I wish to have the following restrictions to the use and disclosure of my health information:
(See attached restrictions written by the patient).

I fully understand and accept ___________. I fully understand and decline ___________.

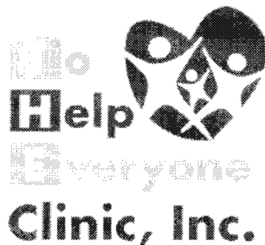
Signature: ______________________________________ Date: __________________.

For Internal Use Only:

"Notice of Health Information Practices" given to patient at this time? Yes / No

If the patient refuses to sign "Consent to the Use and Disclosure of Health Information for Treatment, payment or Healthcare Operations" T.H.E. Clinic staff please sign and date below:

Signature of T.H.E. Clinic staff ______________________________ Date: ______________________



CONSENT FOR TREATMENT

Account Number: ____________________ **Date of Birth:** ______________

____________________	____________________	______________
Last Name	**First Name**	**Middle Name**

I hereby request and authorize diagnostic procedures, laboratory tests, and medical treatment by personnel affiliated with T.H.E. Clinic, Inc. I am aware that my medical care may be provided by Nurse Practitioners, Physicians Assistants, and Medical Doctors. Dieticians, Case Managers and/ or Social Workers may also assist in providing services. Also, I authorize T.H.E. Clinic, Inc. to review my external prescription history.

I acknowledge my responsibility to pay for that care according to the category assigned. I also understand that if I have private insurance, Medicare or Medi-Cal, I may still have to pay part of the fee. I consent to the release of medical and social information to the agency which assumes payment for these services.

T.H.E. Clinic Inc. assures patient confidentiality and will provide safeguards for individuals against the invasion of personal privacy, as required by the Privacy Act (HIPAA). No information obtained by T.H.E. Clinic, Inc. staff about individual's receiving services may be disclosed without the individual's consent, except as required by law or as necessary to provide service. Information may otherwise be disclosed only in summary, statistical, or other form that does not identify the individual.

Your signature below indicates that you have read, understand and agree to the above and you authorize and consent to the treatment and services.

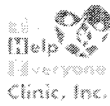
Signature: ________________________________ Date: _______________

Is the patient a minor, or in any way incapacitated to sign for him/her self? ☐ *Yes* ☐ *No*

Relationship to patient: _________________ Print Name: __________________

Witness' Signature: _________________________ ____________________
(STAFF MEMBER) Date

3834 S. Western Avenue • Los Angeles, CA 90062 • Phone: (323) 730-1920 Fax: (323) 732-7786



PATIENT RIGHTS AND RESPONSIBILITIES
Los Derechos y Responsabilidades de los pacientes

Rights:
Derechos:

- You have the right to considerate and respectful treatment.
- Usted tiene derecho a un tratamiénto considerado y respetuoso.

- You have the right to be seen at a time as close to your appointment at possible; understanding that the needs of other patients must also be met.
- Usted tiene el derecho de ser visto al tiempo mas cercano de su cita. Entendiendo que las necesidades del otro paciente deben tambien sean vistas.

- You have the right to seek care at T.H.E. Clinic, Inc.; you will not be refused primary medical treatment because of your financial situation.
- Usted tiene el derecho de buscar cuidado en T.H.E. Clinic, Inc.; usted no sera rechazado para tratamiento medicó debido a su situacion financiera.

- You have the right to examine and receive an explanation of your bill, regardless of source of payment.
- Usted tiene derecho de un examén y de recibir una explicación de su cuenta, sin importar la fuente de pago.

- You have the right to have all physical examinations, interviews, and discussions take place privately and to have all communications and records about your care handled confidentially.
- Usted tiene el derecho de tener todas sus examinaciones fisicas, entrevistas, y discusiones en un lugar privado y de tener todo medio de comunicasiones y expedients sobre su cuidado medicó manejado confidencialmente.

- You have the right to question your provider about anything you do not understand about your care.
- Usted tiene el derecho de preguntar a su doctor preguntas que no entiende sobre su cuidado.

- You have the right to know the names and levels of training of all providers and other staff who take care of you.
- Usted tiene el derecho de saber los nombres y los niveles de entrenamiento de todos los doctores y de personal que tomen en el cuidado de usted.

- You have the right to an understandable explanation of what is wrong with you, what tests and treatments are planned, and what risks are involved. If any tests or treatments, that are not in common use, are planned for you, then you have the right to be informed and asked for your consent.
- Usted tiene el derecho a una explicación comprensible de lo que tenga malo, que pruebas y tratamientos estan planiados para usted, y los riesgos que estan invueltos. Si unas o' tratamientos, que no estan en uso comun, son planiado para usted, entonces tiene el derecho de ser informado y su consentimiento.

- Every patient has the right to offer concerns or complaints about his/her health care received or policies, to the Administration of T.H.E. Clinic, Inc.
- Cada paciente tiene el derecho de ofrecer preocupaciones o' quejas sobre su cuidado medico y las polisas de la clinica, a la administracion.

- You have the right to a second opinion about your care before making a health related decision.
- Usted tiene el derecho a una segunda opinion sobre cuidado antes de tomar una relacionada salud.

- You have the right not to participate in experimental research.
- Usted tiene el derecho de no participar en un experimento de investigación.

Responsibilities:
Responsabilidades:

- You are responsible for conducting yourself appropriately as a patient of the health center. You may not verbally or physically abuse the health center patients, personnel, and/or property.
- Usted es responsable de comportarse apropiadamente como paciente del centro de salud. Usted no puede verbalmente o' fisicamente abusar a otros pacientes, el personal, y la propiedad.

- You have the responsibility to provide accurate proof of your financial situation if you desire reduced charges.
- Usted tiene la responsabilidad de proporcinar la prueba exacta de su situación financiera si usted desea cargos reducidos.

- You are responsible for giving truthful information regarding appropriate questions offered by T.H.E. Clinic, Inc, staff in order to assure proper evaluation and treatment for medical care services.
- Usted tiene la responsabilidad de dar la informacion corecta a las preguntas apropiadas por el personal de T.H.E. Clinic Inc. para asegurar la evalucacion y el tratamiento apropiado para los servicios.

- You are responsible to keep appointments and promptly notify T.H.E. Clinic Inc. if an appointment must be cancelled.
- Usted es responsible en mantener sus citas y notificar a T.H.E. Clinic, Inc. si una cita debe ser cancelada.

- You are responsible to ask questions and discuss concerns with your provider regarding your diagnosis and treatment plan.
- Usted es responsible en hacer preguntas y discutir preocupaciones con su doctor al respecto a su diagnosis y tratatmiento.