DATE: _____

TRUECARE™

PATIENT CONSENT TO TREAT **FORM**

Patient Name	**DOB**	**Sex**	**Social Security Number**
First Middle Last	mm/ dd /yy	M F	- -
Address (☐ Same as Guarantor)	**Phone Number (** ☐ Same as Guarantor)		

ACKNOWLEDGMENT OF RECEIPT OF TrueCare WELCOME PACKET

We understand that information about you and your health is confidential, and we are committed to protecting your health information. As a patient you are required to review and sign this consent form prior to receiving care. Your authorization allows TrueCare staff to use your health information for treatment, payment, and our health care operations. Additional information regarding protection of your medical information can be found in the Notice of Privacy Practice that is included in this packet or may be found on our TrueCare website.

Please initial beside each item that you have reviewed and understand. Items contained in the Welcome Packet are available on the TrueCare website, www.truecare.org for your reference. Welcome Packets are provided to new patients, however, if you would like one or have any questions, please ask for assistance from our front desk employees.

NOTICE OF PRIVACY PRACTICES

( ) Initials I have received a copy of the Notice of Privacy Practices, or a copy was made available to me.

CONSENT FOR TREATMENT, REFUSAL OF TREATMENT, and DISCLOSURE OF HEALTH INFORMATION

( ) Initials I, (the patient, responsible party, or authorized caregiver), authorize TrueCare and its assigned clinical staff to administer and perform all medical treatment, diagnostic, surgical or other services deemed advisable or necessary for healthcare. This care may be delivered either in person or through a virtual health modality. I understand that I have the right to refuse treatment at any time. I can do so by signing a *REFUSAL OF TREATMENT* form. I also give consent to use and disclose health information necessary for treatment and payment and other healthcare operations.

Minor (Patient who are <18 years of Age), Please list both parents or legal guardians:

Mother Full Name: _____ _____ DOB: _____
Father Full Name: _____ _____ DOB: _____
Other, Full Name: _____ _____ DOB: _____
Relationship to Patient: _____

CONSENT FOR ELECTRONIC COMMUNICATION

( ) Initials I, (the patient, responsible party, or authorized caregiver), authorize TrueCare and its clinical staff to communicate with me via my MyChart account by providing visit summaries and Lab results electronically, as well as sending and receiving secure messages. I understand that web-based communication is offered as an option, and I may choose not to register with MyChart.

DATE: _____

Patient Label

CONSENT FOR COMMUNICATION

( ) Initials I, (the patient, responsible party, or authorized caregiver), authorize TrueCare and its clinical staff and any affiliate or agent of TrueCare to contact me or others identified below as a member of my health support group on our cell phones and/or home phones, using pre-recorded messages, artificial voice messages, automatic telephone dialing systems, or other computer assisted technology. I understand that my service provider may charge for such calls. I understand that I am not required to consent to such calls or messages as a condition of receiving medical service. If I do not wish to receive communications at the address or phone number above, I will ask a TrueCare staff member to provide me with a *REQUEST TO CHANGE COMMUNICATION PREFERENCES* form.

CONSENT TO RECEIVE HEALTH CARE SERVICE VIA TELEHEALTH

( ) Initials I, (the patient, responsible party, or authorized caregiver) understand that I have the right to access services through an in-person, face to-face visit or through telehealth. I understand there are Translation services and Transportation services available for services received through TrueCare. 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. I understand that I have options to receive services in person face-to face or via telehealth. If I choose to receive services from TrueCare now or in the future via telehealth, I understand there may be potential limitations and risks related to receiving services via telehealth as compared to an in-person visit. If I have additional questions related to telehealth services, I understand the importance of addressing them with a TrueCare staff.

PERMISSION TO SHARE HEALTH INFORMATION (Optional)

As your healthcare team, we may need to contact you about your health. We would like to invite you to include members of your family and/or others to be part of your health support group. The people you identify below will be permitted to discuss your health information, including but not limited to appointment information, lab results, medication instructions, and referrals information, and they may be contacted for follow-up in case we are unable to reach you. Please provide accurate information for any individuals designated as part of your health support group. Designated persons must show valid photo ID when in a clinic. **To request a paper copy, please complete the AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION form.**

Last Name, First Name	Date of Birth MM/DD/YYYY	Contact Information		Relation to Patient	*Sensitive Health Information
		Phone #			☐ Yes ☐ No
		Address			
		Phone #			☐ Yes ☐ No
		Address			

*Permission to **Share Sensitive Health information** includes mental health treatment information, HIV test results, alcohol, or drug treatment information.

AFFIRMATION OF UNDERSTANDING

My signature below confirms my understanding of TrueCare Consent to Treat.

_____ _____

Patient's/ Parent or Legal Guardian Signature **Date:**

Relationship to Patient: _____ **Copy of legal documents must be scanned into patient's account.*

TrueCare USE ONLY

☐ **Verbal Consent obtained during Virtual Visit.** By Signing below, I acknowledge I have reviewed each section with the patient and "Obtained Verbal" consent to sign on the patient's behalf.

TrueCare Staff Name (PRINT) _____ Sign _____ Date _____

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ASSIGNMENT OF BENEFITS **FORM**

Date: _____

Assignment of Benefits (AOB) is your agreement that helps TrueCare navigate the payment process based on the information provided. If you are insured, it gives TrueCare permission to file a claim and collect insurance payments. **TrueCare will use the following information to verify eligibility and financial liability for the services provided. If services are not covered by the insurance, then this information also helps us assess whether you might qualify for discounts or state programs.**

- You will need to identify **a Guarantor**; the guarantor is the person or entity who is financially responsible for payment on a patient's account. The Guarantor will receive all notifications referencing claims and billing statements.
- Assigning a Guarantor in the registration system will link all associated accounts. Therefore, it is Important that **you list dependents** in your household who are TrueCare patients. Doing so will help TrueCare staff identify you as the Guarantor in the registration system for each Individual listed.
- We verify the guarantor's identity to make sure we don't inadvertently bill the incorrect person for Balances related to the patient's services.

Guarantor Name (Financially Responsible)	**DOB** mm/dd/yy	**Social Security Number**
First Middle Last	mm/ dd /yy	- -
Insurance Company	**Subscriber/Member ID:**	**Group #:**
Is the Guarantor a TrueCare Patient ☐ **Yes** ☐ **No**		

MAILING Address: _____ **City:** _____ **Zip Code**: _____

HOME Address: _____ **City:** _____ **Zip Code**: _____

☐ Same as mailing address

Pimary Phone: _____ **Secondary Phone:** _____

☐ **Cell** ☐ **Home** ☐ **Other:** _____ ☐ **Cell** ☐ **Home** ☐ **Other:** _____

Email Address: _____

Emergency Contact Name: _____ **Emergency Phone #:** _____

Relationship to Patient: _____

Only list Dependents in Household who are TrueCare Patients, the total number supported is documented on next page:			
Last Name, First Name	**Date of Birth** mm/dd/yy	**Relation to Patient**	**Insurance Company** ID & Group # (N/A= if non applicable)

TrueCare™

ASSIGNMENT OF BENEFITS **FORM**

Date: mm/ dd /yy	**Guarantor Name:** First Middle Last	**Date of Birth:** mm/ dd /yy

Eligibility Determination for Sliding Fee Discounts

It is TrueCare's policy to provide essential services to all patients regardless of the patient's ability to pay. Discounts offered are based on the information you provide regarding your family size and income. In order to qualify for the Sliding Fee Discount Program, you will need to declare your income annually or whenever there is a change in your family size or income. This information is strictly confidential and cannot be released without your permission. If you are eligible for a sliding fee discount, it will apply to all services received at TrueCare, but not for those services provided at non-TrueCare facilities. The above statement applies to all household members who are dependents. You acknowledge that you are financially responsible for each dependent member of your household as their Guarantor.

Please complete the following information, (*We recommend that you provide information, even if you have insurance)

My family size (the number in my household supported by this income), including myself, is **_____.**
Household Income, Total **Gross Annual Income**, Before Taxes is **$ _____.**

TrueCare Eligibility for Sliding Fee Discounts, please select one and initial:

I am interested in seeing if I qualify for TrueCare's Slide Fee Discount Program, I have

- ☐ **Self- Declared**, Patient/Guarantor does not have proof of income at this time, will provide it at or before the next appointment. **(____) Initials**
- ☐ **Verified**, Proof of income provided, verified by staff, copy scanned to patient chart. **(____) Initials**

I am declining to provide information on my income and family size and agree to pay the full TrueCare fee.

- ☐ **Refused Application**, Patient/Guarantor is not interested in discounted services at this time. **(____) Initials**

ASSIGNMENT OF BENEFITS

I authorize my healthcare plan/program to reimburse TrueCare for all services I receive. I understand I am responsible for any unpaid balances, co-pays, co-insurance, deductibles, and/or any non-covered services.

☐ If insured, Health insurance card(s) provided: Yes ____ No _____ N/A_____

GUARANTOR/PATIENT'S AFFIRMATION OF INFORMATION

I affirm that the information I have provided to TrueCare is accurate and true to the best of my knowledge. My signature below confirms my understanding of the following:

- **The above statement applies to all household members listed,**
  I acknowledge that I am financially responsible for each dependent individual listed as their Guarantor.
- If I have provided false information, I may be disqualified from the Sliding Fee Discount Program.
- ACCEPTABLE PROOF OF INCOME (Paycheck Stub(s) or Tax Returns) IS REQUIRED FOR THE SLIDING FEE DISCOUNT PROGRAM. IF YOUR FINANCIAL SITUATION CHANGES, PLEASE KEEP TrueCare INFORMED.
- If any information provided on this form changes, I must advise staff at, or before my next appointment.
- TrueCare does not provide refunds for professional services rendered.

Guarantors/Patient's Signature:_____ Date: _____

*(Parent, Guardian, Power of Attorney, or Caregiver). *Copy of legal documents must be scanned into patient's account.*

TrueCare Staff Use:

- ☐ Tele Visit, I obtained verbal consent to sign on behalf of the patient during virtual visit.
- ☐ **AOB** Copies scanned to patient's account associated to Guarantor.

TrueCare USE ONLY

By signing below, I am certifying that this form has been verified for completeness and Guarantor and associated patient's accounts have been updated.

TrueCare Staff Name (PRINT) _____ Sign _____ Location _____

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OB HEALTH & SOCIAL HISTORY

NAME:	DATE OF BIRTH:	DATE
LANGUAGE:	WHERE DID YOU GO TO SCHOOL: _____	YEARS OF EDUCATION: _____
List foods/medicines to which you are allergic:	What OB/GYN problem(s) brought you here today?	
First day of last menstrual period:	Birth Control you and partner using:_____	What would you like to use in the future?
How many times have you been pregnant (including miscarriages & abortions): _____ TOTAL ___ Abortions _____ Pre-term births ____ Miscarriages ___ Full-term births _____ Tubal Pregnancies ____ C-Sections All children living at home? YES NO		Did you have any problems with your pregnancy, miscarriage, abortions, etc? If YES, explain

Circle "Y" for YES and "N" for NO

When was your last PAP smear? _____ Abnormal Y N	Comfortable where you live? Y N
Have you ever had an abnormal PAP smear? Y N If YES, When? _____ How was it treated? _____	Number of adults living in the home: _____ Number of children living in the home: _____ Number of times you have moved within 3 years: _____
Have you ever had a mammogram? Y N If YES, when?_____ Was it abnormal? Y N	Relocating before baby is born: Y N If YES, when? Why?
Are you sexually active now? Y N With men? Y N With women? Y N	Do you often feel sad or blue? Y N Have you ever been physically/sexually abused? If YES, how often?_____
Have you ever had: Y N Gonorrhea Y N Chladmydia Y N Syphillis Y N Pelvic Infection Y N Herpes Y N Vernereal Warts Y N Recurrent Vaginitis Y N Infection of the Uterus or tubes	Do you have/access to a car? Y N Method of transportation: _____ Do you use seatbelts? Y N Do you use car seats? Y N Planning on obtaining a car seat? Y N
At what age was your first period?_____ Are your periods irregular? Y N Are they heavy? Y N	Do you smoke? Y N If YES, how often? _____ Do you use drugs Y N If YES, which one? _____ How often? _____
How often do you get your periods? _____ How many days does your period last? _____	Do you drink alcohol? Y N If YES, how often? _____
Do you have paind with your periods? Y N	History of Depression? Y N **FAMILY** History of Depression? Y N
Do you bleed in between you periods? Y N	Attempted suicide? Y N
Do you bleed after sexual intercourse? Y N	Thoughts of suicide? Y N
Do you have pain with intercourse? Y N	Hospitalized for treatment of substance abuse or depression? Y N
Have you ever had fibroids? Y N	Have you been phsyically and/or sexually abused as a child? Y N
Have you ever had ovarian cysts? Y N	**Partner** been abused as a child? Y N
Have you ever had an operation? Y N If YES, what kind? When: _____	You and your partner ever been physically violent? Y N Physical violence a concern for now in your relationship? Y N Concerns abour your children? Y N
Have you ever been in the hospital for any other problems? Y N If YES, what are they? _____	If YES, explain:
Do you take any medications? Y N If YES, which ones?_____ Dose:_____	Indicate all the ways you like to learn: __ Reading books __ Reading magazines/newspaper __Reading pamphlets __ Watching TV __ Watching videos __ OTHER: _____
List any medical problems:	Programs/Classes and community resources that interest you: __ Childbirth/Lamaze __ Infant Care __ Stress/Anger Management
Have you ever received blood or blood products (a transfusion) in your life? Y N	__ Nutrition __ Parenting __ Substance Abuse (treatment/precention) __ Family Planning (birth control)
Are there any medical problems in your **FAMILY** (mother, father, brothers, sisters, children) such as: Y N High Blood Pressure Y N Breast Cancer Y N Diabetes Y N Heart Disease Y N Ovarian Cancer	Preferred Class Times: ___ DAYS: Monday- Friday 9am-5pm ___ EVENINGS: Monday- Friday after 5pm ___ Weekends: Saturday
Do **YOU** have any problems with: Y N High Blood Pressure Y N Hepatitis Y N Diabetes Y N Heart Problems Y N Headaches Y N Dizzines Y N Lung Problems Y N Anemia Y N Epilepsy Y N Kidney Problems Y N Gallbladder Y N Thyroid Y N Depression/Mental Illness Y N Cancer	What other questions do you have or is there something in which you would like more information?
What is your marital status? SINGLE MARRIED SEPARATED DIVORCED	Do you work outside the home? Y N
With whom do you live with?	If YES, type of work: _____ WHERE:_____ Interested in food assistance program? Y N
Type of housing: HOUSE APARTMENT OTHER:_____	Finances a source of stress for you? Y N

_____ _____ Reviewed with Patient

Providers Signanture Date

Patient ID sticker

Date/Fecha: _____

TrueCare™ TUBERCULOSIS RISK ASSESSMENT

Patient: refers to you or your child depending upon who is visiting the doctor.

High Risk Country: refers to countries other than the United States, Canada, Australia, New Zealand or countries located in Western or Northern Europe.

	YES	NO	FOR TrueCare™ STAFF USE
1. Has the patient had a positive tuberculosis test OR been diagnosed with tuberculosis disease?	☐	☐	Perform symptom check –**NO PPD/QG**
2. Has a family member or other person who has contact with the patient had a positive tuberculosis test OR tuberculosis disease?	☐	☐	PPD Testing or Quantiferon Gold (QG) Testing or Symptom Check as clinically indicated
3. Was the patient born in a high-risk country (see above)?	☐	☐	
4. Has the patient traveled to a high-risk country (see above) for more than 3 weeks in the past year or do they cross the US-Mexico border on a regular basis?	☐	☐	
5. Has the patient ever consumed raw (unpasteurized) milk or cheese (queso fresco) purchased outside of the United States?	☐	☐	
6. In the past year, has the patient had close contact with someone who is homeless, abused drugs, or has been in prison (including themselves)?	☐	☐	PPD/QG Testing
7. Has the patient had a high risk medical condition such as HIV, malignancy, silicosis or prolonged immune suppressing therapy? *Note: HIV positive patients need annual tuberculosis testing.*	☐	☐	

EVALUACIÓN DE RIESGO DE TUBERCULOSIS DE TrueCare™

Paciente: se refiere a usted o a su hijo/a dependiendo de quién consulte al doctor.

País de alto riesgo: se refiere a países que no sean Estados Unidos, Canadá, Australia, Nueva Zelanda ni países ubicados en Europa del Norte u Occidental.

	SI	NO	SOLO PARA PERSONAL DE TrueCare™
1. ¿Ha tenido el/la paciente una prueba positiva de tuberculosis O se le ha diagnosticado tuberculosis?	☐	☐	Perform symptom check- **No PPD/QG**
2. ¿Algún miembro de la familia u otra persona que tiene contacto con el/la paciente ha tenido una prueba de tuberculosis positiva O diagnosticado con tuberculosis?	☐	☐	PPD Testing or Quantiferon Gold (QG) Testing or Symptom Check as clinically indicated
3. ¿El/la paciente nació en un país de alto riesgo (ver definición arriba)?	☐	☐	
4. ¿El/la paciente ha viajado a un país de alto riesgo (ver definición arriba) por más de 3 semanas en el último año o cruzan la frontera de USA-México de forma regular?	☐	☐	
5. ¿El/la paciente ha consumido alguna vez quesos (queso fresco) o leche cruda (sin pasteurizar) que se haya comprado fuera de los Estados Unidos?	☐	☐	
6. En el último año, ¿El/la paciente ha tenido contacto cercano con una persona sin hogar, que ha abusado drogas o que ha estado en prisión (incluso ellos mismos)?	☐	☐	PPD/QG Testing
7. ¿El/la paciente ha tenido una condición médica de alto riesgo como VIH, malignidad, silicosis o terapia inmunodepresora prolongada? *Nota: los pacientes con VIH positivo deben hacerse la prueba de tuberculosis anualmente.*	☐	☐	

Patient Signature /Firma del Paciente: _____ Clinician Signature: _____

FOR TrueCare™ STAFF USE/SOLO PARA PERSONAL DE TrueCare™ — PROBING QUESTIONS/NOTES FOR "YES" ANSWERS

Q1&2: Did the patient have active or latent TB and did they receive Tx or Prophylaxis and if so, did they finish treatment? Hx of BCG? Have they had a CXR if no prophylaxis and if so, when? Q3: Name country Q4: Name country, length of time and when? Q5: Name what, when and where Q6: Consider annual testing if repetitive exposure Q7: HIV+ requires annual testing