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, text messages, SMS messages, or other computer assisted technology. I understand that my service provider may charge for such communications and that standard message and data rates may apply. 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 member.

CONSENT TO USE OF AI-BASED TOOLS

( ) Initials I, (the patient, responsible party, or authorized caregiver) understand that TrueCare utilizes artificial intelligence ("AI")-based tools to support medical treatment in some cases (e.g., the use of clinical decision-support tools), and for various administrative functions. AI-based tools that support administrative functions may include but are not limited to: audio recording the words said during your visit for use in generating the medical record, to update your medical record, and provide you with information on potential diagnoses and treatment plans. These AI-based tools are an aid to the patient and the provider, but ultimately the provider will make a clinical decision using their own professional judgment. I consent to the use of AI-based tools for my medical care and for TrueCare's administrative functions. Information collected during the clinical encounter, including when using these AI-based tools, may be relied on by the provider and become part of the patient's medical record. Such information is stored in compliance with the Health Insurance Portability and Accountability Act, as amended by the HITECH Act, and in accordance with their implementing regulations (collectively, "HIPAA") and other applicable state and federal law and may be used for TrueCare's healthcare operations to further improve the AI model for its patient population.

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 PATIENT ACCESS REQUEST FOR HEALTH IFNORMATION FORM.**

DATE: _____

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 _____

TrueCare™

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. As the **Guarantor** listed on the registration, the Guarantor will receive all notifications referencing a 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 and whom you acknowledge as their Guarantor. Doing so will help Truecare staff assign you as the Guarantor in the registration system for each Individual listed.
- The reason we verify the guarantor's identity and ensure the appropriate guarantor is linked to visit is so that we don't inadvertently bill the incorrect person for balances related to the patient's services.

Patient Information

Patient First Name	Patient Last Name			DOB mm/dd/yy
Mailing Address:	City	Zip Code	State	Primary Phone Number
Email Address:	Emergency Contact Name:			Emergency Contact Phone #

Guarantor Name (*Financially Responsible*)

Patient Relationship to Guarantor: *REQUIRED ☐ Self ☐ Mother / Father ☐ Legal Guardian ☐ Tutor ☐ Spouse

Is the Guarantor a Truecare Patient *REQUIRED ☐ Yes ☐ No

IF the Guarantor is not the patient, please fill out the next section:

First Name of Guarantor:	Last Name of Guarantor:		DOB mm/dd/yy
Mailing Address ☐ Same as Patient, if not fill out next section:			
Mailing Address:	City:	State:	Zip Code:
Home Address ☐ Same as mailing address, if not fill out next section:			
Home Address:	City:	State:	Zip Code:
Phone Number ☐ Same as Patient, if not fill out next section:			
Primary Phone Number ☐ Cell ☐ Home ☐ Other:	Secondary Phone Number ☐ Cell ☐ Home ☐ Other:		
Email Address ☐ Same as Patient, if not fill out next section:			
Emergency Contact ☐ Same as Patient, if not fill out next section:			
Emergency Contact Name:			
Emergency Contact Phone #			

Only add household dependents that are TrueCare Patients

First Name	Last Name	Date of Birth mm/dd/yy	Guarantor Relationship to Patient	Does the patient have Health coverage?
				☐ Yes / No ☐
				☐ Yes / No ☐
				☐ Yes / No ☐
				☐ Yes / No ☐

TrueCare™

ASSIGNMENT OF BENEFITS **FORM**

				☐ Yes / No ☐
				☐ Yes / No ☐
				☐ Yes / No ☐

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.

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**

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	$

☐ **I am declining (Refused Application) to provide information on my income and family size and agree to pay the full TrueCare fee. 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 member listed,**
  I acknowledge that I am financially responsible for each 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 USE ONLY

☐ **Verbal Consent obtained during Virtual Visit.** I acknowledge I have reviewed each section with the patient and obtained verbal consent to sign on the patient behalf. **Staff Initials required** _____

PEDIATRIC HISTORY FORM

PATIENT LABEL

Date: _____

Yes **No** **BIRTH HISTORY**

Where was your baby born? Scripps Tri-City Palomar UCSD Other

How many days was your baby in the hospital? _____ days

☐ ☐ Was your baby born early?

If so, how many weeks early? _____Birth Weight: _____

What type of delivery did you have? Vaginal C-Section Why?_____

MEDICAL HISTORY

☐ ☐ Has your child ever been in the hospital overnight?

Where? _____Why? _____

☐ ☐ Has your child ever had any serious injuries? What?_____

☐ ☐ Has your child ever had any operations? What?_____

☐ ☐ Has your child ever been to the dentist? Last visit? _____

☐ ☐ Does your child take medication on a regular basis? What? _____

☐ ☐ Is your child allergic to any medication? _____

Who provides your child's regular care? _____

Where do you get your child's immunizations? _____

☐ ☐ Has your child ever had a positive TB test? When? _____

☐ ☐ Has your child ever had special blood tests? When? _____ What for? _____

☐ ☐ Any history of Asthma or wheezing? _____

☐ ☐ Any history of anemia? Treated? _____

☐ ☐ Does your child have other medical problems of importance? What? _____

NUTRITION

Yes **No**

☐ ☐ (for infants) are you currently breastfeeding) ☐ ☐ (for infants) has your child started eating solid foods?

☐ ☐ (for infants) are you currently giving your child formula? ☐ ☐ (for toddlers) Is your child still using a bottle?

☐ ☐ (for toddlers) Does your child eat finger foods or feed himself?

☐ ☐ (for school age kids) Does your child eat fruits and vegetables daily?

☐ ☐ Do you have any concerns about your child's nutrition or eating?

DEVELOPMENT

☐ ☐ Do you have any concerns about your child's development?

In which areas do you feel your child is having problems or you have concerns?

Speech and Language Activity and Movements Social Skills Emotions and Behavior

FOR OLDER GIRLS

☐ ☐ Have you started your period? What age? _____

☐ ☐ Are they regular? What was the date of you last period? _____

FAMILY HISTORY

Please check if anyone in the family has had any of the following problems: ____Heart disease ____Diabetes ____

Liver disease ____High blood pressure ____Kidney disease ____Cancer ____Birth disorders _____ Anemia ___

Severe headaches ____Epilepsy ____Mental Illness ____Alcoholism ___Drug abuse

Mother's age: _____Occupation: _____Father's age: _____ Occupation: _____

Are you a single parent? ☐Yes ☐No Who else provides care to your child?_____

How old are your other children? _____ How is their health?_____

What type of housing do you live in? Apartment☐ House ☐ Share rooms ☐ with friends or relatives ☐ Other

How long have you lived there? Less than 3 mo ☐ less than 1 yr ☐ more than 1 yr☐

Is there enough food or clothing for your family? ☐Yes ☐No

Do you have any beliefs that would interfere with medical care? ☐ NO ☐Yes _____

Parent's name:_____

Clinician's signature: _____ Date: _____

Internal use only: clinicians initial and update annually:

_____/_____ _____/_____ _____/_____ _____/_____ _____/_____ _____/_____ ____/_____

_____/_____ _____/_____ _____/_____ _____/_____ _____/_____ ____/_____ ____/_____

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