

DATE: _____

TRUECARE™

PATIENT CONSENT TO TREAT FORM

Patient Name			DOB	Sex	Social Security Number
First	Middle	Last	mm/dd /yy	M F	- -
Address (<input type="checkbox"/> Same as Guarantor)			Phone Number (<input type="checkbox"/> 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.

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

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

TREATMENT, REFUSAL OF TREATMENT, and DISCLOSURE OF HEALTH INFORMATION

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: _____

ELECTRONIC COMMUNICATION

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

COMMUNICATION

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.

HEALTH CARE SERVICE VIA TELEHEALTH

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.

USE OF AUDIO RECORDING

TrueCare may conduct audio recording of 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. You can decline the audio recording and use of AI-based tools to generate notes at each visit. Information collected during the clinical encounter 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 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 INFORMATION FORM.**

DATE: _____

Last Name, First Name	Date of Birth MM/DD/YYYY	Contact Information		Relation to Patient	*Sensitive Health Information
		Phone #			<input type="checkbox"/> Yes <input type="checkbox"/> No
		Address			
		Phone #			<input type="checkbox"/> Yes <input type="checkbox"/> 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	
<input type="checkbox"/>	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 _____



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

(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 your 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.

Table with 7 rows and 3 columns: Question, YES, NO, and FOR TrueCare™ STAFF USE. Questions cover tuberculosis tests, family contact, birth location, travel, diet, and medical conditions.

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.

Table with 7 rows and 3 columns: Question, SI, NO, and SOLO PARA PERSONAL DE TrueCare™. Questions cover tuberculosis tests, family contact, birth location, travel, diet, and medical conditions.

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