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 _____

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. 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 _____

Patient Name:

Patient Date of Birth:

ADULT, ADOLESCENT, & FAMILY PLANNING HISTORY FORM

Date: _____

If we need to contact you to report an abnormal lab test, may we contact you at home? ☐ Yes ☐ No

If no who may we contact? Name: _____ Phone: _____

In a medical emergency whom shall we contact? Name: _____ Phone: _____

Relationship Do they know you are a patient here? ☐ Yes ☐ No

FAMILY HISTORY

Has anyone in your family had trouble with any of the following:

Yes	No	Who		Yes	No	Who	
☐	☐	_____	Hepatitis or Liver problems	☐	☐	_____	Tb or lung problems
☐	☐	_____	High Blood Pressure	☐	☐	_____	Birth Defects
☐	☐	_____	Heart Attack before age50	☐	☐	_____	Diabetes
☐	☐	_____	Heart Attack after age 50	☐	☐	_____	Cancer of _____
☐	☐	_____	Stroke before age 50	☐	☐		Did your mother take DES while pregnant with you?
☐	☐	_____	Stroke after age 50				

MEDICAL HISTORY

Yes	No	When		Yes	No	When	
☐	☐	_____	Heart attack or problems/Chest pains	☐	☐	_____	Liver problems
☐	☐	_____	Diabetes	☐	☐	_____	Hepatitis B vaccinated
☐	☐	_____	Blood clots in legs	☐	☐	_____	Kidney Disease/Urine problems
☐	☐	_____	High Blood Pressure	☐	☐	_____	Prostate problems
☐	☐	_____	High Cholesterol	☐	☐	_____	Gall bladder problems
☐	☐	_____	Anemia/Sickle Cell/Blood problems	☐	☐	_____	German Measles
☐	☐	_____	Migraine Headaches	☐	☐	_____	Chlamydia/Gonorrhea/Syphilis
☐	☐	_____	Epilepsy/Seizure	☐	☐	_____	Herpes
☐	☐	_____	Asthma/Lung problems	☐	☐	_____	HIV
☐	☐	_____	Positive TB Test	☐	☐	_____	Breast Disease
☐	☐	_____	Thyroid Problems	☐	☐	_____	Frequent vaginal infection
☐	☐	_____	Anxiety or Emotional Problems	☐	☐	_____	Uterine Fibroids/Uterine infection
☐	☐	_____	Severe Depression	☐	☐	_____	Abnormal PAP smear/Colposcopy

Have you ever had any operations? ☐ Yes ☐ No **What** _____

Do you take medications regularly? ☐ Yes ☐ No **What** _____

Do you smoke? ☐ Yes ☐ No **How many cigarettes?** _____

Do you drink? ☐ Yes ☐ No **How many drinks?** _____

Are you allergic to medications? ☐ Yes ☐ No **Which ones?**

Are you allergic to latex products ☐ Yes ☐ No **Do you use street drugs?** ☐ **Yes** ☐ No **What?**

Do you need help with daily activities? If *Yes*, What? _____

FEMALES ONLY:

First day of your last period? _____

Age your period started _____

Periods come every _____ days

Do you have ☐ Severe cramps ☐ Premenstrual tension

Your periods ☐ Irregular ☐ Regular

Your periods ☐ Light ☐ Moderate ☐ Heavy

Do you spot or bleed between periods? ☐ Yes ☐ No

Date of Last Pap _____ Normal: ☐ Yes ☐ No

PREGNANCY HISTORY

Total number of pregnancy(ies) _____

Number of live births _____

Number of miscarriages _____

Number of abortions _____

Are you planning to get pregnant? _____

If *Yes*, when? _____

Are you taking Folic Acid? _____

CONTRACEPTIVE HISTORY

Have you had any unprotected sexual intercourse in the last 2 months? _____

What contraceptive method do you currently use? _____

Do you have any problems with this method? _____

Have you missed any pills, injections, forgotten to use diaphragm or condom, or had a condom break in the last 2 months? ☐ Yes ☐ No

Check all methods that you have used in the past Any problems with other methods? ☐ Yes ☐ No

☐ Pills ☐ Patch ☐ Nuva Ring ☐ Diaphragm ☐ IUD

☐ Condoms ☐ Injection ☐ Jelly ☐ Foam and condoms ☐ None

SEXUAL HISTORY

Age you first engaged in sexual activity?

Number of sexual partners in the past two (2) years: _____

Your sexual partner(s) have been from the: ☐ Same sex ☐ Opposite sex ☐ Both sexes

Have you ever had a partner that used injectables drugs or had sex with a same sex partner? ☐ Yes ☐ No

Has anyone close to you ever hit, slapped, pushed, kicked, or physically hurt you in any way? ☐ Yes ☐ No

Has anyone ever forced you to do something sexually that you didn't want to do? ☐ Yes ☐ No

Clinician: _____ 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

Staying Healthy Assessment

Senior

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ Other *(Specify)*		Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Do you have difficulty chewing or swallowing?	No	Yes	Skip	
8	Are you concerned about your weight?	No	Yes	Skip	
9	Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day?	Yes	No	Skip	Physical Activity
10	Do you feel safe where you live?	Yes	No	Skip	Safety
11	Do you often have trouble keeping track of your medicines?	No	Yes	Skip	
12	Are family members or friends worried about your driving?	No	Yes	Skip	
13	Have you had any car accidents lately?	No	Yes	Skip	
14	Do you sometimes fall and hurt yourself, or is it hard to get up?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone in the past year?	No	Yes	Skip	
16	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
17	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
18	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
19	Do you often have trouble sleeping?	No	Yes	Skip	
20	Do you or others think that you are having trouble remembering things?	No	Yes	Skip	

21	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
22	Do friends or family members smoke in your house or where you live?	No	Yes	Skip	
23	In the past year, have you had 4 or more alcohol drinks in one day?	No	Yes	Skip	
24	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
25	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	Sexual Issues
26	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
27	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
28	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
29	Do you have someone to help you make decisions about your health and medical care?	Yes	No	Skip	Independent Living
30	Do you need help bathing, eating, walking, dressing, or using the bathroom?	No	Yes	Skip	
31	Do you have someone to call when you need help in an emergency?	Yes	No	Skip	
32	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐
☐ Independent Living	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date: