PATIENT CONSENT TO TREAT AND ACKNOWLEDGEMENT OF PRIVACY PRACTICES

CONSENT FOR EVALUATION AND TREATMENT

I consent to medical treatment from U.S. HealthWorks Medical Group (USHW), its affiliates, physicians, and employees. Treatment may include any necessary examination, test, or medical procedures ordered by the physician(s) to be performed by USHW staff. I understand I may refuse treatment at any time. If I am seeking non-regulated substance abuse testing, I authorize USHW to obtain a specimen of my urine, blood, saliva, breath, hair, or other specimen to determine the presence of drugs or alcohol. I understand that some physical exams (like fitness for duty, school, or sports) and other services are not intended to diagnose medical conditions or replace the medical care of my personal physician.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have reviewed or have been given an opportunity to review the USHW Notice of Privacy Practices (NPP). I have had an opportunity to ask questions about it and received satisfactory answers. I may ask for a copy of the NPP or can view it electronically at http://www.ushealthworks.com

ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITY AGREEMENT

- If I am being treated as an urgent care patient for a non-work-related injury and I have health insurance, I assign to USHW all payments under the terms of my applicable insurance policies.

- If I am being treated as an urgent care patient for a non-work-related injury and I **do not** have health insurance, I understand I am responsible for payment. I have a right to ask for the charge amounts before electing treatment.

- If I am treated for a workers' compensation injury or illness, USHW will seek payment from the responsible payer, which is typically the employer or the employer's workers' compensation insurance carrier. I may be responsible for a co-payment where allowed by law.

- If I am receiving employer-directed services (e.g. drug testing, physicals, medical surveillance) USHW will seek payment from the employer. I may be responsible for payment if allowed by State or Federal law.

- If I am responsible for payment and my account is referred to collections, I understand that I may have to pay collection expenses incurred by USHW.

SIGNATURE

Patient Signature:_____ Date:_____

Patient Name:_____ Date of Birth:_____

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PRIVATE PATIENT INFORMATION

PATIENT INFORMATION: (Información del Paciente) Date (Fecha):_____

Name (Nombre): Last (Apellido):_____ First (Nombre):_____

Current Address (Dirección):_____ City (Ciudad)_____ State(Estado)_____ Zip(C. Postal)_____

Phone (No teléfono en casa): ( )_____ Work Phone (No teléfono en trabajo):: _____

Date of Birth (Fecha Nacimiento):_____ Cell (Celular): (____)_____ SS:_____ Sex(o): _____

Emergency Contact (En caso de emergencia) Name (Nombre):_____ Tel:(

Marital Status (Estado Marital): ❒Single (Soltero) ❒Married (Casado) ❒Other (Otro):_____

Employment: ❒Employed (Empleado) Student (Estudiante):❒FT (Tiempo completo) ❒PT (Tiempo Parcial) ❒Other (Otro):_____

E-mail Address (Correo electrónico):_____ Occupation (Ocupación):_____

Employer (Empleador) Name (Nombre):_____

Address (Dirección):_____ City (Ciudad)_____ State (Estado)_____ Zip (C.Postal)_____

Have you ever been treated at US HealthWorks before? (Ha sido tratado alguna vez en US HealthWorks? ❒Yes (Sí) ❒No

RESPONSIBLE PARTY INFORMATION: (Información de la persona responsable)

❒Check here if responsible party is also the patient. If so, continue in the next section.
(Si la persona responsable es también el paciente, marque la casilla y continue en la sección siguiente)

Name (Nombre): Last (Apellido):_____ First (Nombre):_____ Sex(o):_____

Current Address (Dirección):_____ City (Ciudad)_____ State(Estado)_____ Zip(C.Postal)_____

Home Phone (No teléfono en casa): ( )_____ Work Phone (No teléfono en trabajo):: ( )_____

Date of Birth (Fecha Nacimiento):_____ Cell (Celular): ( )_____ SS:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS (Por favor conteste las siguientes preguntas):

Is this visit for a new illness or condition? (¿Se debe esta visita a una nueva enfermedad o condición?) ❒Yes (Si) ❒No

Illness Date (Fecha de enfermedad):_____ Similar Illness Date (Fecha con enfermedad similar):_____

Referring Physician (Médico que Refiere):_____ Patient Insured? (¿Paciente Asegurado?) ❒Yes (Sí) ❒No

Bill Employer? (¿Para cobrarle al empleador?) ❒Yes (Sí) ❒No

Do you have, or are you eligible for Medicare part A or B? (¿Tiene o es elegible para Medicare A o B?) ❒Yes (Sí) ❒No

INSURANCE INFORMATION (Información de su compañía de seguros)

Subscriber Name (Suscritor): Last (Apellido):_____ First(Nombre):

Cell (Celular): (___)_____

Current Address (Dirección):_____ City (Ciudad)_____ State (Estado)_____ Zip (C.Postal) _____

Home Phone (Teléfono en casa): ( )_____ SS:_ DateofBirth(FechaNacimiento):_____

Relationship to Insured (Relación con asegurado): ❒Patient (Paciente) ❒Spouse (Cónyuge) ❒Child (Hijo(a)) ❒Other (Otra):_____

Patient Signature: _____

By signing above I consent to have U.S. HealthWorks contact me by automated phone call and/or text message about future appointments at the number(s) I have provided. I understand I do not need to give this consent to receive treatment.

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HEALTH HISTORY / HISTORIA MEDICA
URGENT CARE / CUIDADOS DE URGENCIA

TO BETTER ASSESS YOUR HEALTH AND ITS IMPACT IN THE RESOLUTION OF YOUR CONDITION, ANSWER THE FOLLOWING QUESTIONS. CIRCLE ANY SPECIFIC ITEMS IN EACH SECTION THAT APPLY TO YOU AND EXPLAIN ANY YES ANSWERS IN THE SPACE AT THE BOTTOM OF THE PAGE.

PARA EVALUAR MEJOR SU SALUD Y EL EFECTO EN LA RESOLUCIÓN DE SU ENFERMEDAD, CONTESTE LAS SIGUIENTES PREGUNTAS. MARQUE CON UN CÍRCULO CUALQUIER CONDICIÓN EN CADA SECCIÓN QUE APLIQUE EN SU CASO Y EXPLIQUE EN LA PARTE BAJA DE LA PAGINA CUANDO SU RESPUESTA SEA "SI".

PAST MEDICAL, FAMILY AND SOCIAL HISTORY / *ANTECEDENTES MÉDICOS, FAMILIARES Y SOCIALES*

1	No	Yes/Si	Have you ever had any medical allergies? *¿Alguna vez ha sufrido de alergias médicas?*	5	No	Yes/Si	Currently on any medications? If YES, list medications and dosage below. *¿Toma alguna medicina? Si responde SI, liste las medicinas y dosis abajo.*
2	No	Yes/Si	Have you ever had recurrent illnesses or major injuries? *¿Ha sufrido de enfermedades/ lesiones importantes?*	6	No	Yes/Si	Have you ever had hospitalizations or surgeries? *¿Alguna vez ha tenido hospitalizaciones u operaciones?:*
3	No	Yes/Si	Do you currently have a chronic illness such as: • High blood pressure, heart disease, stroke • Diabetes, thyroid disease, liver disease, kidney disease • Mental illness, seizures or movement disorders? *¿Sufre usted de alguna enfermedad crónica como:* *• Presión alta, enfermedades del corazón, trombosis,* *• Diabetes, enfermedades de la tiroides, hígado o riñones,* *• Enfermedades mentales, convulsiones o movimientos involuntarios?*	7	No	Yes/Si	Have any direct relatives suffered from: blood diseases, cancer, leukemia, diabetes, heart disease, high blood pressure, strokes, mental illnesses or other? *¿Han sufrido sus familiares directos de alguna enfermedad como: presión alta, diabetes, enfermedades del corazón, ataques, convulsiones, enfermedades del hígado o riñones, o enfermedades mentales?*
4	No	Yes/Si	Do you use tobacco? If 'Yes' state type and quantity per day. *¿Usa usted tabaco? ¿Indique tipo y cuánto por día?*		No	Yes/Si	Do you consume alcohol? If YES, state type and quantity. *¿Consume bebidas alcohólicas? Si responde SI, indique tipo y cantidad.*

REVIEW OF SYSTEMS / *REVISION DE SISTEMAS*

Circle any items that apply in each section and explain further below. *Marque con un círculo cualquier condición que aplique a su caso en cada sección y explique abajo.*

HAVE YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING? / ***¿HA PRESENTADO USTED RECIENTEMENTE ALGUNOS DE LAS SIGUIENTES CONDICIONES?***

9	No	Yes/Si	**CONSTITUTIONAL** / ***CONSTITUCIONAL*** Fever, chills, fatigue, body aches or weight gain or loss? *Fiebre, escalofrios, fatiga dolor en el cuerpo o cambios significativos de peso?*		No	Yes/Si	**SKIN** / ***PIEL*** Cancer, tumors, cysts or other? *¿Cáncer, tumores, quistes u otros problemas?*
10	No	Yes/Si	**HEAD** / ***CABEZA*** Trauma, injuries, or frequent or severe headaches? *¿Golpes, lesiones o dolores de cabeza?*	17	No	Yes/Si	**EYES** / ***OJOS*** Trauma, injuries, Infections, burning, itching or light sensitivity? *¿Trauma, lesiones, infecciones, picazón, quemazón o sensibilidad a la luz?*
11	No	Yes/Si	**CARDIOVASCULAR** / ***CARDIOVASCULAR*** Palpitations, shortness of breath, chest pain/pressure, swelling in legs/feet? *¿Palpitaciones, dificultad para respirar, presión en el pecho, hinchazón de las piernas o pies?*	18	No	Yes/Si	**GENITOURINARY** / ***GENITOURINARIO*** Blood in urine, painful/frequent urination, kidney stones, venereal diseases? *¿Orina con sangre o dolor, orina frecuente, cálculos de riñón, enfermedades venéreas?*
12	No	Yes/Si	**EARS,NOSE,THROAT** / ***OIDOS,NARIZ,GARGANTA*** Ear pain, trouble hearing, sore throat or pain swallowing, sinus pain or disease, nasal allergies? *¿Dolor de oídos, sordera, dolor de garganta, sinusitis, alergias nasales?*		No	Yes/Si	**MUSCULOSKELETAL** / ***MUSCULOSQUELÉTICO*** Joint pain, neck or back pain, broken bones? *¿Dolor en las articulaciones, dolor en la espalda o el cuello, fracturas?*
13	No	Yes/Si	**RESPIRATORY** / ***RESPIRATORIO*** Asthma, wheezing, emphysema, bronchitis, tuberculosis or coughing of blood? *¿Asma, silbidos al respirar, enfisema, bronquitis, tuberculosis, tos con sangre?*		No	Yes/Si	**NEUROLOGICAL** / ***NEUROLÓGICO*** Dizziness, muscle weakness, numbness? ¿Mareos o vértigo, debilidad muscular, falta de sensación?
14	No	Yes/Si	**GASTROINTESTINAL** / ***GASTROINTESTINAL*** Abdominal pain, indigestion or reflux, nausea or vomiting, blood in vomit or stool, constipation, diarrhea, ulcers, diverticulitis? *¿Dolor abdominal, indigestión o reflujo, nausea o vómitos, vómitos o heces con sangre, constipación, diarrea, úlceras digestivas, diverticulitis?*	21	No	Yes/Si	**ENDOCRINE** / ***ENDOCRINO*** Thirst, increased urination, hair loss, thyroid disease, osteoporosis? *¿Sed, aumento de la orina, perdida notable del cabello, problemas de tiroides, osteoporosis?*
15	No	Yes/Si	**BLOOD DISORDERS, CANCER** / **ENFERMEDADES DE LA SANGRE** Anemia, spontaneous or easy bleeding, bruising, cancer? ¿Anemia, moretones o cardenales, sangramiento, cáncer?		No	Yes/Si	**FOR MEN ONLY** / ***PARA HOMBRES SOLAMENTE*** Penile discharge, prostate problems, genital pain or masses? *¿Secresiones en el pene, problemas de próstata, dolor o masas genitales?*
23	No	Yes/Si	**FOR WOMEN ONLY** Painful or irregular menstruation, vaginal discharge or pain? Are you pregnant?	23	No	Yes/Si	***PARA MUJERES SOLAMENTE*** *¿Menstruación o periodos dolorosos o irregulares, secreciones o dolor vaginal?* *Esta Usted Embarazada*

PLEASE WRITE THE NUMBER OF ANY "YES" ANSWERS ABOVE AND EXPLAIN EACH ONE OF THEM HERE.
Por favor, escriba aquí el número de las preguntas en las cuáles haya contestado que SÍ y explíquelas a continuación.

PROVIDER COMMENTS

I certify that the information provided above is correct. (*Certifico que la información suministrada es correcta.*)

Patient Signature *(Firma del Paciente)*:_____ Date *(Fecha)*:_____

☐ Relevant history was discussed with patient.
☐ Advised to follow up with personal physician.

Provider Signature:_____

IF ID LABELS ARE USED, AFFIX HERE AND DO NOT COVER ANY OF THE TEXT ABOVE.

UC HEALTH HISTORY

Name:_____ Incident #:_____ Date:_____

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