TruMedical
CARE
255 Herndon Ave #102, Clovis, CA 93612
559-550-6226 / Fax 559-550-6262

We look forward to meeting you at your upcoming appointment at TruMedical Care. Please print and complete the attached forms for your scheduled appointment.

Please bring the completed packet with you to your appointment.
Also, please remember to bring the following:

- ✓ Your Insurance Card(s)
- ✓ IF YOU HAVE **HMO INSURANCE,** DR. LEE COPELAND NEEDS TO BE LISTED ON YOUR INSURANCE CARD AT THE TIME OF YOUR VISIT
- ✓ Any Co-Payment due required by your insurance
- ✓ Photo ID
- ✓ Bring ALL Medications to appointment

Please plan to arrive 15 minutes prior to your scheduled appointment time.

Thank you and we look forward to seeing you.

TruMedical Care
A Physician Assistant Healthcare Partner Corporation

TruMedical
CARE

Patient Demographic Form

Patient Information

Date: _______________

Name: ____ Date of Birth: ____/____/_______ SSN: _______________________
(Legal Name Listed on Insurance Card)

Preferred Name: _____________________________________ Parent/Guardian (if applicable):_____________________________

Race: ☐ Black/African American ☐ White/Caucasian ☐ Native Hawaiian/Other Pacific Islander
☐ American Indian/Alaska Native ☐ Asian ☐ Unknown ☐ Other or Prefer not to specify

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Prefer not to specify

Preferred Language: ☐ English ☐ Spanish ☐ Hmong ☐ Lao ☐ Punjabi ☐ Hearing Impaired/Sign
☐ Vietnamese ☐ Other ☐ Prefer not to specify

Translator: ☐ Yes ☐ No

Address: ____City: _________________State: _____ Zip Code:______________

Phone (H)_____________________________(C)________________________________(W)________________________________

Preferred Phone # to confirm appointment: ________________________E-Mail Address: _________________________________

Can we communicate to you by E-Mail: Yes _____ No _____ AND/OR Texting: Yes _____ No _____

Marital Status: Single _____ Married _____ Other _____

Employer: ____ Occupation: ______________________________________

Employers Address: ___________________________________ City: _________________State: _____ Zip Code: ______________

Work Status: Employed _____ Unemployed _____ Retired _____ Disabled _____

Insurance Information

Primary Insurance Company:____

Name of Policy Holder: _________________________________Relationship to Patient: ________________ Date of Birth:_________

Policy Holder I.D. No.: ____ Group No.: _____________________________

Insured's Employer: ____(If different from above)

Secondary Insurance Company:____

Name of Policy Holder: _________________________________Relationship to Patient: ________________ Date of Birth:_________

Policy Holder I.D. No.: ____ Group No.: _____________________________

Insured's Employer: ____(If different from above)

Injury Information

Work Related Injury? Yes _____ No _____ If Yes, Date of Injury: ______________

Auto Accident Injury? Yes _____ No _____ If Yes, Date of Injury: ______________

Emergency Contact

Name: ____Phone: ________________________Relationship: _________________

HIPAA information release to:____
(I authorize TruMedical to use and disclose a copy of specific health and medical information to the above. I understand that the above request will remain in effect until I request a change and fill out another form. Signature ____________________________)

TruMedical CARE

A Physician Assistant Healthcare Partner Corporation
255 Herndon Ave #102, Clovis, CA 93612 ••• 559-550-6226 / Fax 559-560-6262 ••• www.trumedicalcare.com

New Patient Medical History - Please complete this two-sided form prior to your first appointment (Page 1)

Name: ____ Date of Birth: _____/_____/_____ Age:______ Sex: ______

♦ Other Physicians and Specialists ♦

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)

♦ Please briefly state in the box below the reason for your visit ♦

♦ Medication or Food Allergies or Intolerances ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	***Reaction***	***Medication / Food***	***Reaction***

♦ Medications, Vitamins and Herbal Supplements ♦

Preferred Pharmacy: ______________ Cross Streets: ___________________________________ Phone Number: ________________

Medication	***Strength***	***Number of pills taken & frequency***	***Medication***	***Strength***	***Number of pills taken & frequency***
Eg: *Tylenol*	*500 mg*	*1 - twice daily*			

♦ Past Medical History ♦

Condition / Disease	***Year Began***	***Condition / Disease***	***Year Began***
❑ Hypertension		Other(s):	
❑ High Cholesterol			
❑ Hypothyroidism (low thyroid)			
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ Heartburn/Reflux			
❑ Depression or Anxiety			
❑ Heart Problems			

TruMedical CARE

A Physician Assistant Healthcare Partner Corporation
255 Herndon Ave #102, Clovis, CA 93612 ••• 559-550-6226 / Fax 559-560-6262 ••• www.trumedicalcare.com

New Patient Medical History - Please complete this two-sided form prior to your first appointment (Page 2)

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦

Operation / Hospitalization / Injury	*Month / Yr*	*Operation / Hospitalization / Injury*	*Month / Yr*

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	*Living or Deceased*	*Current age or age at death*	*Cause of Death*	*Health Problems*
Father:				
Mother:				
Brother(s):				
Sister(s):				

♦ Social, Educational and Work History ♦

Are you a current smoker? Yes / No Cigarettes / cigar / vaping / chew (circle)	If you smoke or smoked, how many packs per day?	
Are you a former smoker? Yes / No	If so, what year did you quit?	No. of years you smoked?
Do you drink alcohol? Yes / No	What type of alcohol?	No. of drinks per week?
Do you use drugs? Yes / No / Not currently / Never If Yes, list drugs:		
Are you sexually active: Yes / No / Not currently / Never If Yes, with: Men / Women / Both	How many partners have you had during the past 12 months?	
What do you use for birth control?		
Work Status (circle one): Employed / Unemployed / Retired / Disabled	Current or Prior Occupation:	Highest Level of Education:
Marital Status: Single / Married / Other	Spouse's name:	Number of children, if any:
If female, number of pregnancies: ________ miscarriages: ________ abortions: ________ live births: ________		

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests

	Month/Yr		*Month/Yr*		*Month/Yr*
Flu Vaccine		Hepatitis B Vaccine		Colonoscopy	
Pneumonia Vaccine 13		Mammogram		EKG	
Pneumonia Vaccine 23		Pap Smear		Heart Stress Test	
Tetanus/ Tdap Vaccine		Bone Density		Heart Catherization	
Shingles Vaccine		Eye Exam		Abd Aneurysm Screen	

Adult Review of Systems

Patient Name:________________________________ Date:______________

Have you had any of these problems?

Head and Neck
_______ frequent headaches
_______ neck pains
_______ neck lumps or swelling

Eyes
_______ wears glasses if so for
_______ reading ______ distance _____ bifocals
_______ contact lens
_______ blurry vision
_______ eyesight worsening
_______ sees double
_______ sees halo
_______ sys pains or itching
_______ watering eyes

Ears
_______ hearing difficulties
_______ earache
_______ drainage from ears
_______ buzzing in ears
_______ motion sickness

Mouth
_______ dental problems
_______ swelling on gums or jaw
_______ sore tongue
_______ taste change

Nose and Mouth
_______ congested nose
_______ running nose
_______ sneezing spells
_______ head colds
_______ nose bleeds
_______ sore throat
_______ enlarged tonsils
_______ hoarse voice

Respiratory
_______ wheezes or gasp
_______ coughing spells
_______ coughed up blood
_______ chest colds
_______ more sweating, night sweats

Cardiovascular
_______ high blood pressure
_______ racing heart
_______ shortness of breath
_______ more pillows to breathe
_______ chest pains

how far can you walk without getting short of breath? _______

_______ swollen feet or ankles
_______ heart murmur

Digestive
_______ heartburn
_______ bloated stomach
_______ belching
_______ stomach pains
_______ nausea
_______ vomited blood
_______ difficulty swallowing
_______ constipation
_______ loose bowels
_______ black stools
_______ clay colored stools
_______ pain in rectum
_______ rectal bleeding

Urinary
_______ night frequency _____ # of times
_______ day frequency _____ # of times
_______ wets pants or bed
_______ burning on urination
_______ coca cola color or bloody urine
_______ difficulty starting urine
_______ urgency to urinate

Male Genital
_______ weak urinary system
_______ prostate trouble
_______ burning or discharge
_______ lump on testicle
_______ painful testicle

Female Genital
_______ last menstrual period ____/____/____
_______ post-menopause
_______ hysterectomy
_______ ovaries removed? yes or no
_______ uses hormones
_______ uses birth control pills
_______ irregular periods
_______ heavy bleeding
_______ vaginal itch or discharge
_______ lump or pain in breast
_______ regular mammograms
_______ last pap test ____/____/____

Number of
_______ pregnancies
_______ live births
_______ abortions
_______ miscarriages

Current Medications
____
____
____

Musculoskeletal
_______ aching muscles or joints
_______ swollen joints
_______ red joints
_______ back or shoulder pain
_______ painful feet

Skin
_______ changes in mole
_______ itching or burning skin
_______ frequent sun exposure/tanning

Neurological
_______ seizures
_______ weakness or numbness
_______ tremors
_______ poor memory

Mood
_______ nervous with strangers
_______ difficulty in making decisions
_______ lack of concentration
_______ lonely or depressed
_______ cries often
_______ hopeless outlook
_______ difficulty relaxing
_______ worries a lot
_______ frightening dreams or thoughts
_______ loses temper
_______ work or family problems
_______ sexual difficulties
_______ considered suicide
_______ desires counseling

General
_______ gained/lost more than 10 lbs.
_______ tends to be hot or cold
_______ loss of appetite
_______ always hungry
_______ armpits or groin swelling
_______ sleeping difficulties
_______ exercise less than 3 times a week
_______ smoker? ______packs/day ____years
_______ 2 or more alcohol drinks/day
_______ over 6 cups of coffee per day
_______ uses tranquilizers
_______ uses recreational drugs
_______ uses narcotics

place visited in last 6 months __________

_______ cataracts? ______right ______left eye
_______ glaucoma
_______ date of last eye exam ____/____/____
_______ change in family history?
_______ Current age

Special Problems To Discuss: ____
____
____

Signature ________________________________

TruMedical CARE

FINANCIAL POLICY

Payment in full is required at the time of service for all services provided in the physician's office, unless you fall into one of the categories listed below. All patient co-payments are due and payable at the time of service. If you are unable to make your co-payment at the time of service and your appointment is not of an emergency nature, we reserve the right to reschedule your appointment until such time as you are able to make your co-payment.

No Show Policy: No show appointments and failure to cancel your appointment within 24 hours of your scheduled appointment will result in a $35.00 fee for all office visits. The fee must be paid in full prior to any further appointment.

Insurance Billing: As a courtesy, this facility will bill your insurance, if you belong to any of the HMO's and PPO's we are currently contracted with. It is your responsibility to make sure that we have current copies of your card(s), and completed claim forms necessary as well as correct billing addresses. Please note that you, as the patient, are responsible for knowing the scope of your health coverage benefits, IE: Well Child Care, Annual Physicals, etc. **If special notations are needed for wellness exams, it is your responsibility to make us aware.**

Worker's Compensation: THIS OFFICE DOES NOT TREAT, NOR WILL WE BILL FOR WORKERS COMPENSATION INJURIES. Please contact your employer for more information.

Personal Injury of MVA: As a courtesy, this facility will bill the patient's MVA Insurance, if all the necessary information is provided at the first visit. To avoid litigation, this facility will not bill any Third-Party Liability Insurance or accept liens for these types of injuries on any patient. A copy of an itemized billing statement will be provided upon request for the patient to submit for reimbursement directly for all Third-Party Claims. Patient will be responsible for payment in full should the claim be denied by insurance or payment is delayed for more than 60 days.

Returned Checks: There will be a $20.00 service charge on all returned checks.

Monthly Statements: Statements are generated for this facility on a monthly basis via "cycle" billing. They are a request for payment due of what is currently a "patient due" responsibility. All patient balances are due and payable upon receipt of the statement, unless special payment arrangements have been made with the billing department in advance.

I have read the above policy and agree to comply with its provisions. I understand that I am responsible for all medical services rendered. I understand that if I am covered by a third-party payment service such as an insurance plan, our office will provide an itemized billing statement upon request, but I am personally responsible for billing such charges to any third-party payer and are responsible for all charges until they are paid in full. In the event of collection action, I shall be responsible for any legal fees incurred.

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to TruMedical Care and That I am financially responsible for services that the insurance considers to be non-covered. I authorize TruMedical Care to release any information required to process my claim.

Patient Name (Print): ____ Date of Birth: ______________________

Patient/Responsible Party Signature: ____ Date: ______________________

TruMedical CARE

255 W. Herndon Ave #102, Clovis, CA 93612
559-550-6226 / Fax 559-550-6262

It is our mission at TruMedical Care to provide the best possible patient care and service to each of our valued patients. We have implemented a few new policies to reduce confusion and misunderstanding between our patients and practice so we are able to continue to thrive with excellent patient care. Please read, review, and sign the following policies that have been implemented as of July 1, 2022.

MISSED APPOINTMENT: Failure to cancel your appointment within 24 hours of your scheduled appointment will result in a $35.00 fee for all office visits. Fee must be paid in full prior to any further appointments.

INSURANCE: All patients must be prepared to present current insurance cards at time of visit if requested. We will be unable to make any outside referrals without a current insurance card. For Telehealth visits including video, you will be liable for payment if your insurance does not cover such visits.

REFERRALS: Please allow 7-10 business days to process any referrals.

APPOINTMENT NOTIFICATION: Please provide an email, current updated phone numbers and an updated emergency contact person we may reach if needed.

MEDICATION: Please bring ALL Medications and/or detailed list of medications to all office visits.

PATIENT CONDUCT: Our goal as your provider is to provide exceptional care and respect to all patients. Our office does require our patients to use appropriate conduct to our providers and staff. Inappropriate conduct may result in dismissal of patient care.

Patient Name: ____ DOB: ______________________

Email:____ Best Contact #: ______________________

Emergency Contact Name:____________________________ Emergency #: ______________________

Signature: ____ Date: ______________________

TruMedical
CARE

255 W Herndon Ave #102, Clovis, CA 93612
559-550-6226 / Fax 559-550-6262

PATIENT CONSENT

CONSENT:

I hereby give consent for medical treatment to the attending physician to care for myself or I am duly authorized by the patient as his/her general agent to give consent of such treatment. I hereby give consent for release of medical information to consulting physicians and other medical personnel, as may be required in the rendering of treatment.

I hereby provide my consent for TruMedical Care to obtain my prescription History using the Sure Scripts network. I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefits Managers and retail pharmacies. I also understand that Sure Scripts has certified that prescription History Capture follows strict security protocols to align with HIPAA requirements and respect patient privacy.

AUTHORIZATION:

I hereby authorize payment directly to the attending physician of any medical benefits payable to me under the conditions of my policy for services rendered. I hereby give consent for release to authorized person of financial and medical information concerning care, treatment and charges as may be required to complete all claims for benefits.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pays or balance due for these services if they are not reimbursed by my insurance for whatever reason.

ACKNOWLEDGEMENT:

My signature below acknowledges that I have read the Consent/Notice of Patient Privacy Practice Policy and understand the disclosures and consents.

Patient Signature: ____ Date: ___________________
and /or Responsible Party

Printed Name: _______________________________ Relationship to Patient: _______________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or other health care operations and for other purposes that are permitted or required by law. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. We are required by law to maintain the privacy of your medical information and to provide you with notice of our legal duties and privacy practices. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change those terms and any changes made will be effective for all protected health information that we maintain. Upon your request we will provide you with a copy of our revised notice by accessing our web site, www.trumedicalcare.com, calling the office and requesting that a revised copy be sent to you in the mail, or asking for one at the time of your next appointment.

I. Permitted Uses and Disclosures of Protected Health Information

- Treatment: Your physician will use or disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g. a specialist or a laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.
- Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include activities that your health plan may undertake before it approves or pays for health care services that we recommend for you. These activities include: determining eligibility, reviewing services for medical necessity, and utilization review activities.
- Health Care Operations: We may use or disclose your protected health information to support the business activities of our office. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may use a sign in sheet at the front desk where you will be asked to sign your name and indicate your physician, we may call you by name in the waiting room when your physician is ready to see you, or we may use your information as necessary, to contact you to remind you of an appointment.
- Central California Health Information Exchange We participate in the Central California Health Information Exchange (the "Exchange"), which is an electronic health record that is shared with other health care providers who participate in the Exchange and, in other certain limited circumstances, with other health care providers who are not Exchange participants, such as a specialist to whom you have been referred. Your electronic health record may also be available electronically for a health care provider to access when it is determined that you require emergent care.

II. Uses and Disclosures Based on Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization unless otherwise permitted or required by law as described below. You may revoke an authorization, at any time, in writing, except to the extent we have relied on the use or disclosure of protected health information indicated in the authorization.

III. Permitted Uses and Disclosures Without Your Authorization or Opportunity to Object Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Public Health: We may disclose your protected health information for public health activities and purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the Food and Drug Administration regarding drugs and medical devices.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may be required to disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to a subpoena or administrative tribunal (to the extent such disclosure is expressly authorized).

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. For example, to provide information about someone who is or is suspected to be a victim of a crime, to provide information about a crime at our office, or to report a crime that happened somewhere else.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes or to determine the cause of death; to a funeral director, as authorized by law, to aid in burial; or to organizations that handle organ and tissue donations.
Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
Criminal Activity: We may use or disclose your protected health information to prevent a serious threat to health or safety.
Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.
Business Associates: We may disclose your protected health information to third party "business associates" who perform health care operations for us and who agree to keep your health information private.
Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

IV. Patient Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to request access or a copy of your protected health information. You may request access and/or a copy of your medical information maintained in our records, including medical and billing records. Your request must be in writing. Following is our fee schedule for copying medical records:

Patient Request: $25-$35 (determined by chart size)

You have the right to request a restriction of your protected health information. You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We do not have to agree to the request, however if we do, we will abide by your request except as required by law, in emergencies, or when the information is necessary to treat you. You may request a restriction by completing a "Restriction Request Form" available at the front desk. You will receive a response in writing within seven (7) days of receiving your request.

Your physician may deny the restriction request if he/she believes it is in your best interest to permit the use and disclosure of your protected health information.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our office manager.

You have the right to request an amendment to your protected health information. You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us from which we may prepare a rebuttal. TRUMEDICAL will provide you with a copy of any such rebuttal. Please fill out an "Amendment Request Form" available at the front desk if you would like to request that an amendment be made to your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations or pursuant to a valid authorization as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2023. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

V. Complaints

If you believe we have not properly protected your privacy, have violated your privacy rights, or you disagree with a decision we have made about your rights, you may contact our Corporate Privacy Officer, David Pena (559) 550-6226 or by e-mail at david@trumedicalcare.com. You may also send a written complaint to the U.S. Department of Health and Human Services, Office for Civil Rights as follows:

U.S. Department of Health and Human Services
Office for Civil Rights
Attn: Regional Manager
50 United Nations Plaza, Room 322
San Francisco, CA 94102
1-415-437-8310

TruMedical Care will ensure that you will not be penalized nor will the care you receive at our facilities be impacted if you file a complaint.

This notice was published and becomes effective on April 14, 2023.

TruMedical
CARE
A Physician Assistant Healthcare Partner Corporation
255 W Herndon Ave #102, Clovis, CA 93612 ••• 559-550-6226 / Fax 559-550-6262 ••• www.trumedicalcare.com

HIPAA RELEASE/NOTICE OF PRIVACY PRACTICES CONSENT FORM

By my signature below, I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices for TruMedical Care. I also understand that Medical doctors are licensed and regulated by the Medical Board of California. The Medical Board may be reached by phone at (800) 633-2322 or email at www.mbc.ca.gov.

Name of Patient or Personal Representative____

Signature of Patient or Personal Representative____

Date ______________________ Relationship of Personal Representative Authority________________________

Patient Disclosures & Consents

HIPAA Release

I (Name of Patient) ____, authorize TruMedical to use and disclose a copy of specific health and medical information to the following:

I understand that the above request will remain in effect until I request a change and fill out another form.

Name of Recipient: ____Relationship to Patient: ______________

Name of Recipient: ____Relationship to Patient: ______________

Name of Recipient: ____Relationship to Patient: ______________

Signature of Patient: ____Date: ____________________

255 W Herndon Ave, Suite 102, Clovis, CA 93612
Phone (559) 550-6226 / Fax (559) 550-6262

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

EXPLANATION: This authorization for use of disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act 0 1981, Section 56 et. seq., California Civil Code.

AUTHORIZATION: I ____/_________________ hereby authorize:
(Patient's Name) **(Date of Birth)**

____

____

____

Phone: _________________________ Fax: ________________________

INFORMATION TO BE RELEASED TO:

TruMedical Care
255 W Herndon Ave, #102
Clovis, CA 93612
Fax (559) 550-6262

SEND THE FOLLOWING RECORDS:

_____ History / Physical _____ Imaging Reports _____ EKG / Treadmill
_____ Lab Results _____ Consults _____ Medication List

_____ All Records Specific Dates of Treatment: ______________ to _______________

USES: The requested may use the medical records and type of information authorized only for the following purposes: Assisting in appropriate treatment of present medical condition.

DURATION: This authorization shall become effective immediately and shall remain in effect until ______________________.

RESTRICTION: I understand that requester may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

ADDITIONAL COPY: I further understand that I have a right to receive a copy of this authorization upon my request. Copy requested and received: Yes No Initials_________

____ ____________________
Signature: (Parent/Patient/Legal Representative) Date:

Witness: ____

255 W Herndon Ave, Suite 102, Clovis, CA 93612
Phone (559) 550-6226 / Fax (559) 550-6262

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

EXPLANATION: This authorization for use of disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act 0 1981, Section 56 et. seq., California Civil Code.

AUTHORIZATION: I hereby authorize:

TruMedical Care
255 W Herndon Ave, #102
Clovis, CA 93612

INFORMATION TO BE RELEASED TO:

____ Pick Up: ___

____ Mail: ___

____ Fax: ___

Phone: __________________ Fax: _______________

____ _____________ ______________________
(Patient's Name) **(Date of Birth)** **(Phone Number)**

I give authorization for ______________________________ /____________________ to pick up my records.
(Name) **(Relationship to Patient)**

SEND THE FOLLOWING RECORDS:

_____ History / Physical _____ Imaging Reports _____ EKG / Treadmill
_____ Lab Results _____ Consults _____ Medication List

_____ All Records Specific Dates of Treatment: _____________ to ______________

USES: The requested may use the medical records and type of information authorized only for the following purposes: Assisting in appropriate treatment of present medical condition.

DURATION: This authorization shall become effective immediately and shall remain in effect until ______________________.

RESTRICTION: I understand that requester may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

ADDITIONAL COPY: I further understand that I have a right to receive a copy of this authorization upon my request. Copy requested and received: Yes No Initials_________

____ ____________________
Signature: (Parent/Patient/Legal Representative) Date:

Witness: ____