Community Medical Wellness Centers USA®

REGISTRATION FORM

Community Medical Wellness Centers, USA. (CMWC) attempts to provide low or no cost services to the community. CMWC is a Federally-Qualified Health Center and is **REQUIRED** to obtain the following information on all persons who use services at CMWC – no matter what the service. Please take a moment to answer the following questions as accurately as possible. This information will be kept confidential. You only have to complete this form once (per year) for each type of service/program.

PATIENT INFORMATION

First Name: _____ **Middle Name:** _____ **Last Name:** _____

Date of Birth: _____ **Social Security #:** _____

Address: _____ **Zip Code:** _____
City State

Home Telephone #: _____ **Message/Other Telephone #**: _____

Gender (must select one):
☐Female ☐Male ☐Transgender (FtoM) ☐Transgender (MtoF) ☐Choose not to disclose ☐Other_____

Sexual Orientation (must select one):
☐Heterosexual (straight) ☐Lesbian or Gay ☐Bisexual ☐Don't Know ☐Choose not to disclose ☐Other _____

Race (must select one):
☐Native Hawaiian ☐Other Pacific Islander ☐Asian ☐Black/African American
☐American Indian/Alaska Native ☐White ☐More than one race ☐Refuse to Report / **Other**: _____

Hispanic/Latino Ethnicity (must select one):
Do you consider yourself to be Hispanic, Latino or Chicano? ☐Yes ☐No

Language Spoken at Home: _____

How many family members in the home? _____

Total Household Income – include social security/disability/unemployment benefits, child support, alimony, etc. received: Cannot be $0 – must report how you are supporting yourself:

$_____ (select one) weekly/every other week/monthly/annually

Are you a Veteran? ☐Yes ☐No **Are you a Migrant or Seasonal Farmworker?** ☐Yes ☐No

Do you have a renter's lease or mortgage in your name or your spouse/partner's name? ☐Yes ☐No

Insurance: ☐**Medicare** ☐**Medi-Cal** ☐**Self-Pay (cash)** ☐**None** ☐**Public Program:** _____
☐**Private (please specify):** _____

EMERGENCY CONTACT INFORMATION

Name _____ **Relationship** _____ **Telephone#**: _____

Address: _____

IF PATIENT IS MINOR: Please list the names of the parents that are responsible for this child.

Name: _____ DOB: _____ Relationship:☐Parent ☐Guardian

Name: _____ DOB: _____ Relationship:☐Parent ☐Guardian

I affirm that the statements made herein are true and correct to the best of my knowledge.

X_____ _____
Patient/Responsible Person's Signature Date

Community Medical Wellness Centers USA

YOUR KEY TO WELLNESS

AUTHORIZATION TO CONSENT TO TREATMENT

I, _____, voluntarily request and provide Community Medical Wellness Center, USA with my permission to perform reasonable and necessary outpatient medical, psychological and mental health examinations and treatments, including diagnostic, laboratory, x-ray and imaging testing and procedures. By signing below, I am indicating that; (1) I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) I consent to treatment at this office or any other satellite office of Community Medical Wellness Center, USA. The consent will remain fully effective until it is revoked in writing, which may be at any time to discontinue services.

I understand that I have the right to discuss the treatment plan with my health care provider about the purpose, potential risks and benefits of any test ordered or treatment recommended, and may refuse such are, interventions, services, medications or treatment at any time. I consent to have a physician, nurse practitioner, physician assistant and/or mental health provider, or their designees as deemed necessary, to perform reasonable and necessary medical, psychological and mental examinations, testing and treatment for condition which has brought me to seek care at Community Medical Wellness Center, USA. I further understand that I have not been given any guarantees as to the results of the services I will receive.

LIMITS OF CONFIDENTIALITY

Federal and state regulation require that strict client confidentiality be maintained at all times, except when there is evidence of potential injury to oneself and/or others; potential injury to you by someone else; suspected child abuse, spousal abuse, and/or elder abuse; or certain medical conditions that require reporting to the Department of Health or Department of Motor Vehicles. In such instances we are required to report to the appropriate authorities/agencies. In accordance with these regulations, we will not disclose any information about you or your participation in this program to any person or institution including school personnel and other family members, without your written consent, except as set forth above.

Do you understand the Limits of Confidentiality that I have discussed with you? YES_____(initials) N O _____(initials)

RELEASE OF INFORMATION

I, the undersigned, do hereby authorize CMWC, upon inquiry, to make available to the public certain basic information about the patient, including name, address, age, sex, general description of the reason for treatment (whether an injury, burn, poisoning, or other conditions) and general nature of the injury, burn, poisoning, or other condition, and general conditions. If the patient or the patient's legal representative does not want such Information to be released, he/she must have a written request or such information to be withheld.

CMWC will obtain the patient's consent and his/her written authorization to release information, other than basics information, concerning the patient, except in those circumstances when CMWC is permitted or required by law to release information.

ADVANCED DIRECTIVES

Advanced Directives are legal documents that provide instructions regarding your medical care decisions. We encourage you to discuss your treatment decisions with the medical staff.

Would *you* like to receive more information regarding Advanced Directives? □Yes □ N o

PATIENT'S RIGHTS

In accordance with section 70577(k) and 71507(a), Title 22, of the California Administrative Code, CMWC and the medical staff have adopted certain patient rights. The undersigned acknowledges that he/she received a copy of the Patient's Bill of Rights.

CONSENT TO REVIEW MEDICATION HISTORY

I, the undersigned, do hereby authorize CMWC to obtain my medication history via their electronic medical system record system to ensure appropriate treatment and continuity of care. This consent shall remain effective unless it is revoked in writing and delivered to CMWC.

Patient Signature: _____ Date: _____

Print Name: _____

If Patient is a minor, responsible parent must write name and sign here: _____

Relationship to patient: _____

Witness Signature: _____ Title: _____

Print Name: _____

Community Medical Wellness Centers USA
YOUR KEY TO WELLNESS

After-Hours Care

For emergencies, please dial 911 or go to your nearest hospital emergency room.

CMWC ensures that our patients can speak with an on-call provider after business hours.

To reach the on-call provider, simply call (562) 270-0324 and stay on the line, you will then be directed to our after-hours answering service. Simply inform the operator that you need to speak to a provider, and you will be asked for the patient's full name, date of birth, and contact # to be called back.

ATENCIÓN FUERA DEL HORARIO REGULAR

Para emergencias, marque el 911 o vaya a la sala de emergencias del hospital más cercano.

CMWC se asegura de que nuestros pacientes puedan hablar con un proveedor de guardia después del horario comercial.

Para comunicarse con el proveedor de guardia, simplemente llame al (562) 270-0324 y permanezca en la línea, luego lo dirigirán a nuestro servicio de mensajes después de las horas normales de consulta. Simplemente informe al operador que necesita hablar con un proveedor y se le pedirá el nombre completo del paciente, la fecha de nacimiento y el número de contacto para que le devuelvan la llamada.

ការថែទាំក្រៅម៉ោងធ្វើការ

សំរាប់ការជាបន្ទាន់, សូមចុចទៅលេខ 911 ឬក៏ ទៅកាន់បន្ទប់សង្គ្រោះបន្ទាន់នៅមន្ទីរពេទ្យដែលនៅជិតអ្នកបំផុត។

CMWC ធានាបានថាអ្នកជំងឺរបស់យើងអាចនិយាយជាមួយគ្រូពេទ្យប្រចាំការ នៅក្រោយម៉ោងធ្វើការ ។

ដើម្បីជួបជាមួយគ្រូពេទ្យប្រចាំការ សូមទូរសព្ទ៍ទៅកាន់លេខ (562) 270-0324 និងរង់ចាំបន្តិចសិនកុំដាក់ទូរសព្ទ៍ចុះ

អ្នកនឹងត្រូវបានគេដាក់ផ្ទាល់ទៅកាន់សេវាកម្មឆ្លើយតបក្រោយម៉ោងធ្វើការ។ អ្នកគ្រាន់តែជូនដំណឹងដល់អ្នកឆ្លើយតាមទូរសព្ទ៍ថា

អ្នកត្រូវការនិយាយជាមួយគ្រូពេទ្យ ហើយអ្នកនឹងត្រូវបានគេសួរពី ឈ្មោះពេញរបស់អ្នកជំងឺ, ថ្ងៃខែឆ្នាំកំណើតរបស់អ្នកជំងឺ

និងលេខទូរសព្ទ៍សំរាប់អោយគេទូរសព្ទ៍ត្រឡប់ទៅវិញ។