MEDICAL HISTORY

病歷

病人姓名： DOB：_______________

Past Medical History and Review of Systems

Please circle the problems you had before or have now:

請圈選曾患過或現有之症狀

1. High blood pressure 高血壓
2. Diabetes 糖尿病
3. Cancer 癌症
4. Heart disease 心臟病
5. Chest discomfort 胸部不適
6. Shortness of breath 氣喘
7. Swollen ankles 腳腫
8. Dizziness 頭暈
9. Palpitation 心悸
10. Frequent urination 頻尿
11. Rheumatic fever 風濕熱
12. Asthma 哮喘
13. Bronchitis 支氣管炎
14. Pneumonia 肺炎
15. Persistent cough 久咳
16. T.B. 結核病
17. Hay fever 枯草熱
18. Abdominal pain 腹痛
19. Indigestion 消化不良
20. Nausea 噁心
21. Vomiting 嘔吐
22. Constipation 便秘
23. Diarrhea 腹瀉
24. Blood in stool 便血
25. Peptic ulcer 消化性潰瘍
26. Weight loss 體重減輕
27. Hemorrhoids 痔瘡
28. Gall bladder disease 膽囊病
29. Colitis 大腸炎
30. Hepatic desease 肝病
31. Change in bowel habit 大便習慣改變
32. Thyroid disease 甲狀腺疾病
33. Irradiation 放射治療
34. Headache 頭痛
35. Kidney disease 腎臟病
36. Kidney stone 腎結石
37. Urinating problem 泌尿問題
38. Arthritis 關節炎
39. Low back pain 腰背痛
40. Skin disease 皮膚病
41. Blood disorder 血液病
42. Venereal disease 性病
43. Anxiety 焦慮症
44. Depression 憂鬱病
45. Anemia 貧血
46. Gout 痛風

Others 其他：____

____

____

Allergies to Medications, X-Ray dyes, or Other Substances？

對藥物，X光顯影劑或其他醫藥物有無過敏？ Yes 是 No 無

Name of medicine 藥物名稱	Type of reaction 反應狀況
_______________	________________________________
_______________	________________________________

Regular medication (name and dosage) 日常服用之藥名及劑量：

____

____

____

Operations 曾作過之手術：

____

(next page please) 請接下頁

Do you smoke 您抽煙嗎？No 不☐

Yes 有☐，packs/day 每天包數 __________

Do you drink 您喝酒嗎？No 不☐

Yes 有 ☐ ， how much/often 數量/次數________

Immunization history and preventive medicine 疫苗接種及預防醫學記錄：

Pneumovax 肺炎疫苗	No 無☐	Yes 有☐，When 何時？______________
Flu shot 流行性感冒	No 無☐	Yes有☐，When 何時？______________
Hepatitis B: B 型肝炎	No 無☐	Yes有☐，When 何時？______________
Tetanus 破傷風	No 無☐	Yes 有☐，When 何時？______________

The most recent date of the following exams 曾於何時作過下列檢查？

Pap smear 子宮頸抹片 ____________	Breast exam 乳房檢查 ____________
Mammogram 乳房攝影 ____________	Stool for blood 大便潛血 ____________
Prostate exam 攝護腺 ____________	Cholesterol check 膽固醇 ____________

Family History 家族史：

Has any member of your family (parents, grandparents, siblings) ever had the followings ?

您的祖父母，父母，兄弟姐妹曾患有下列疾病嗎？

Illness 病名	Family member 家屬關係	Age of onset 發病年齡
Cancer (type) 癌症 (種類) _________	______________	______________
High blood pressure 高血壓	______________	______________
Heart disease 心臟病	______________	______________
Diabetes 糖尿病	______________	______________
Stroke 中風	______________	______________
Mental disease 精神疾病	______________	______________
Bleeding disease 出血疾病	______________	______________
Others 其他：________________	______________	______________

Signature 簽名：______________________ **Date** 日期：______________

CCACC Pan Asian Volunteer Health Clinic

Date: ______________(mm/dd/yy)

Section: Patient Detail

English Name: ____________ ____________ ________ ____________________

姓 Family Name 名 First Middle 中文姓名 Chinese Name

地址 Address: ____

City: ____________________ State: ________ Zip: __________

電話 Phone: (____) ____________________ (____) ____________________

Home Work/ Mobile

Email: ________________________

SSN #: ________________________

DL #: ________________________

Oth ID #: ________________________

EIN/NPI/UPIN/Other MRN/ other

生日 DOB: __________________ (mm/dd/yyyy)

Signed HIPAA: __________________ (mm/dd/yyyy)

性別 Gender: Male/Female

婚姻狀況: Marital Status: Divorced/Married/Partner/ Single/Unknown/Widowed/Legally Separted

醫生 Primary Provider: __________________

Signed Release Information from other clinic to Pan Asian: __________________ (mm/dd/yyyy)

Confidentiality: 1 - No Special Restriction / 6 - Extreme Confidentiality

Primary Practice: CCACC - Pan Asian VHC

Emergency contact name & phone number, different from home 非同住之緊急聯絡人

Name 姓名 ________________Phone 電話 __________________Relationship 關係 ____________

Section: Statistics I

County of Residence:

Montgomery/ Fairfax /Howard/ PG /__________

語言 Language: Chinese/ Thai/ ______________

英語程度 English Proficiency:

Proficient 流利 / Somewhat Proficient 還好 /

Limited Proficient 會一點 / Not Proficient 不流利/

Unknown / Blank

Ethnicity 種族: Hispanic or Latino 西班牙 /

Not Hispanic nor Latino / Unknown

Race 族裔: Asian / White / Native Am /

Black/other____________

Shelter Type: Shelter / Homeless / Has Home /

Transition Program / Unknown

House Hold Status: Head of Household 戶主 / Not Head of Household 非戶主/Unknown / Blank

Number of Adult: _____

Number of Children Under age of 19: ________
Financially Responsible for # of Children: _______

家庭收入 Household Income: $ ______________ (Weekly 每週 / Biweekly 雙週 / Monthly 每月/ Annual 每年)

家庭年收入 Annual Household Income: $____________

Religion: Buddhist,Muslin,Catholic,Protestant,Mormon,Jehovah's,Witness,OtherChristian,Jewish,Orthodox, Hindu, Other, Unknown, Blank

原居國 Country of Origin:

China / Taiwan / Macau / Hong Kong / USA /

Vietnam / Bermuda / Malaysia / Indonesia /

Thailand / N. Korean / S. Korean / Unknown

Occupation: ____________________

US Veteran: No / Yes

醫護機構 Registration Location:

CCACC – Pan Asian VHC /
Mobil Med / Other

Employment: Employed / Retired / Unemployed / Unknown / Blank

Education Level: __________________

Referred by: __________________

____

Patient signature 病人簽名

Section: Participation I

Program: Montgomery Cares

Start Date: __________ (mm/dd/yyyy)

End Date: __________ (mm/dd/yyyy)

Number of Adults: __________

Number of Children under 19: __________

Annual Household Income: $__________

Expires: Yes / No

Status: Active / Inactive

Shelter Type: Shelter / Homeless / Has Home / Transition Pgm / Unknown

Proof of Residency:

Driver's License
Letter: County or State
Letter: Host w/Residency Proof
Letter: Landlord
Letter: Shelter Staff or Case Manager
Maryland State ID Card
Mortgage / Lease
Property Tax Bill
Recent Pay Stub w/Address
Signed Federal Tax Return /W2
Utility Bill
Voter Registration Card
School Records

Proof of Age:

Declared Age
Other
Photo ID
Blank

Proof of Income:

Alimony/Child Support Statement
Disability/Unemployment Statement
Employment Termination Letter
Income Letter: Relative/Friend
Letter From Employer
No Income Letter: Patient/Other
Pay Stubs: Most Recent 2 Weeks
Signed Federal Tax Return
Social Security/SSI Award Letter
(Blank)

CCACC PAN ASIAN VOLUNTEER HEALTH CLINIC
9318 Gaither Road, Suite 205, Gaithersburg, MD, 20877
Tel: 301-798-6001 or 240-393-5950
Fax: 240-668-9828

PATIENT CERTIFICATION AND CONSENT FORM

I certify that all of the information provided to CCACC Pan Asian Volunteer Health Clinic (CCACC-PAVHC) is true and accurate to the best of my knowledge. I hereby voluntarily consent to medical treatment by the medical staff and providers of CCACC-PAVHC. I further consent to the use and disclosure of my protected health information for treatment, payment, operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act without a written authorization. A copy of this agreement may be used in place of the original. This authorization is valid until I rescind it in writing.

______________________________________ ___________________________

Signature of Patient or Parent/ Legal Guardian Date

____

Print Name

Chinese Culture and Community Service Center, Inc.
Pan Asian Volunteer Health Clinic
9318 Gaither Road, Suite 205, Gaithersburg, MD, 20877
Tel: 301-798-6001 or 240-393-5950
Fax: 240-668-9828

FREE CLINIC FEDERAL TORT CLAIMS ACT (FTCA) PROGRAM
Patient Notice of Limited Liability of FTCA Deemed Volunteer Free Clinic Health Care Professionals
Notice to Patients

To be provided
to the individual patient before health care services are provided,
except in emergency cases when notice may be provided
as soon after the emergency as is practicable
or
to a parent or legal guardian when the patient lacks legal responsibility for his/her care under
State law.

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA), (See 28 U.S.C. §§ 1346(b), 2401(b), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by any free clinic volunteer health care practitioner who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. § 233(a), (o)).

Certain free clinic health care professionals providing health care services to patients at this free clinic may be covered by the above Federal law.

Acknowledged: ______________________________ (patient signature)

______________________________ (patient name, printed legibly)

Date: ______________________________

CCACC-PAVHC

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding
CCACC-PAVHC's Notice of Privacy Practices.

The confidentiality of your protected health information is important to us. This is a summary of CCACC-PAVHC's Notice of Privacy Practices, which contains a more detailed description of how our Clinic will protect your health information, your rights as a patient and our practices in dealing with patient health information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you, and in order to obtain payment for our services. We may also disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care, unless you object;
- For certain limited research purposes;
- For purposes of public health safety, or to avert a threat to health and safety;
- To government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to report or prevent abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by law.
- For organ or tissue donations, or to the coroner or medical examiner;
- For Workers Compensation;
- To Business Associates who may help us with Clinic services.

Uses and Disclosures Based on Your Authorization. Except for the circumstances stated above and as allowed under the federal Health Insurance Portability and Accountability Act, we will not use or disclose your health information without your written authorization.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;

- To request that we amend your health information;
- To receive notice of our privacy practices;
- To complain to the Clinic or government agencies;
- To revoke any authorization in writing;
- To obtain more information about our privacy practices.

If you have a question, concern, or complaint regarding our privacy practices, please refer questions to the Privacy Officer (Clinic Director) at 240-393-5950.

TITLE: PATIENT GRIEVANCE POLICY POLICY NO: 506

POLICY:

This policy is to ensure that all patients who visit the Clinic will be treated with respect, consideration, and dignity.

PROCEDURE:

1. All patients are to be assured confidential treatment and non-disclosure of records, and afforded the opportunity to approve or refuse the release of such information, except as otherwise permitted by law of third party payment contract and when release is required by law.
2. Each patient will be made aware of the name and function of any person providing health care services to the patient.
3. The Clinic's Patient Bill of Right will be posted in the waiting area in an area visible to all patients.
4. If at anytime during the course of the visit, the patient is dissatisfied with the treatment being provided, to include the unprofessional behavior of the staff, the patient has the right and is encouraged to file a grievance. The grievance must be filed with the Medical Director or the Clinic Director.
5. All complaints should be filed in writing and a response will be provided in writing within two weeks.
6. The Medical Director and/or the Clinic Director will take the following actions,
    a. Conduct a thorough investigation of all complaints and maintain an office file.
    b. Maintain anonymity of patients, staff and volunteers when required.
    c. Seek medical, legal or other professional advice as warranted.
    d. Administer recommended disciplinary action.
7. Staff and volunteers may also file a letter of complaint pertaining to patients and forward written comments and witness statements to the Medical Director and/or the Clinic Director.

CCACC-PAVHC

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the Practice's Privacy Notice.

______________________________________ ______________________

Name of Individual (Printed) Date of Birth

______________________________________ ______________________

Signature of Individual or Personal Representative Relationship if other than patient

Authorization for Use and Disclosure of Medical Information
For eClinicalWorks

I, ______________________ [INSERT NAME OF PATIENT], a patient at CCACC-Pan Asian Volunteer Health Clinic ("My Clinic") understand that eClinicalWorks is a computer-based health information exchange comprised of member healthcare providers like My Clinic (members of eClinicalWorks are called "eCW Members") whose purpose is to provide improved health care to individuals like me by allowing providers who treat me to have access to my medical records. I understand that, unless I notify My Clinic that my medical information may no longer be shared with eClinicalWorks, my medical information (as defined below) will be provided to eClinicalWorks and will be available to eCW Members for purposes of providing me with health care services as further described below, and as otherwise may be permitted by law. However, I understand that even if I notify My Clinic requesting that my medical information no longer be shared, my medical information will continue to be available to eCW Members through eClinicalWorks in certain limited situations as permitted by law (for example, in order to avert a serious threat to the health and safety of myself or others).

- *Purpose of use or disclosure of my medical information.* I am authorizing the sharing of my medical information with eClinicalWorks, which allows eCW Members to more easily share my medical information, as defined below, for the purpose of providing me with health care services.
- *Information that is covered by this Authorization.* This Authorization covers information about me that is created or received by My Clinic, as well as other eCW Members, in the course of providing health care services to me, including but not limited to medical, personal and family household information (together called "my medical information"). This Authorization also covers medical information that eCW Members receive from other providers.
- *Who may receive, use, or disclose my medical information.* I am authorizing only eClinicalWorks to receive, use and disclose my medical information among eCW Members, including their staff. This Authorization does not allow the disclosure of my medical information to individuals or entities other than eClinicalWorks and eCW Members, except as otherwise permitted or required under federal or state law.
- *Term of Authorization.* This Authorization will remain in effect, unless revoked by me, for a period of ten (10) years from the date I sign this Authorization or any shorter period that may be required by law.

I understand that I may at any time make a written request to My Clinic, or any other eCW Member, to inspect or obtain a copy of my medical information and that the eCW Member will either contact me for a convenient time to inspect or copy my medical information or provide me with a copy or summary of my medical information. I further understand that I may obtain from My Clinic or any other eCW Member a complete list of eCW Members. I understand that a copy of this Authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records.

I understand that the medical information disclosed under this Authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected by law to the same extent as such medical information was protected by law while solely in the possession of the eCW Member.

I understand that I may refuse to sign this Authorization at any time for any reason and that my refusal to sign this Authorization will not affect the commencement, continuation or quality of treatment of me by My Clinic or any other eCW Members, unless otherwise permitted by law.

I understand that eCW Members will not sell or receive compensation for the use or disclosure of medical information that is identifiable to me.

I understand that I may revoke this Authorization at any time and that such revocation will not affect the commencement, continuation or quality of treatment of me by eCW Members. In order to revoke this Authorization, I understand that I should submit to My Clinic or any other eCW Member a written request to revoke this Authorization. The revocation will be effective upon receipt by an eCW Member of my written request to revoke, except to the extent that action already has been taken in reliance on this Authorization.

I have read and understood the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my medical information. Accordingly, I knowingly and voluntarily authorize any eCW Member to use or disclose my medical information in the manner described above. I understand and agree that this Authorization applies only to the extent that an Authorization is required by law in order for eCW Members to use or disclose my medical information in the manner described above.

I understand that I can notify My Clinic or any other eCW Member at anytime of my wish to revoke this Authorization and no longer share my health information electronically.

______________________________ __________________________

Signature of Patient Date

If the patient is a minor or otherwise unable to sign this Authorization, please complete the following and provide a copy of documentation that authorizes you to act as the personal representative:

______________________________ __________________________

Signature of Personal Representative Relationship Date

Printed Name of Personal Representative　　Staff Signature/ Title

Strategy for urgent and emergency situations

Since PAVHC mainly takes care of chronic medical conditions, whenever patients have urgent or emergency situations, please be advised of the following strategies:

1. In case the patient needs to be seen before the next scheduled appointment, our manager will arrange the patient to be seen at the earliest available appointment.

2. If the patient's condition is relatively urgent, he/she should see the local practitioner or urgent care at his/her own cost. A list of doctors can be found from the local yellow page or newspapers.

3. If the patient's condition is a life threatening emergency, he/she should call 911 or go to the local emergency room at his/her own cost.

<u>病情有特殊與緊急狀況之處理</u>

由於泛亞門診主要治療非急性之疾病，若其間病人有特殊或緊急之狀況，請按以下建議處理:

1. 若病情需要在下一次預約之前覆診，門診經理會安排病患提前回診。

2. 若病情相對緊急，可到其他私人診所或 Urgent care clinic 看病（可從黃頁或報紙查閱），費用自行處理。

3. 若病情危急或有生命危險，請打 911 或到附近之急診室就醫，費用自行處理。

病患或家屬簽名, Signature of Patient or Relative