

Ridgecrest Regional Hospital

1081 N. China Lake Blvd.

Ridgecrest, CA 93555

(760)446-3551

Pediatric TB and Lead Risk Assessment Questionnaire

Name of Child:	Date of Birth:	Today's Date:
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Risk Factors For Tuberculosis in Children:		YES	NO	Don't Know
1.	Was your child born in an area that is high-risked for Tuberculosis?			
2.	Has your child traveled to an area that is high risk for T for more than 1 Week? If yes, specify which country:			
3.	Has a family member or contact had Tuberculosis disease?			
4.	Has a family member had a positive TST or IGRA results?			
5.	Has your child spent time (more than 3 weeks) with anyone who has been in jail/prison, homeless, shelter, uses illegal drugs, or has HIV?			
6.	Does your child drink raw milk or eat unpasteurized cheese?			
7.	Does your child have a household member who was born in an area that is high risk for Tuberculosis?			
8.	Does your child have a household member who has traveled to an area that is high risk for Tuberculosis			

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

Risk Factors For Lead Poisoning in Children:		YES	NO	Don't Know
1.	Does your child play or reside in a house with peeling or chipping paint?			
2.	Does your child have meals cooked or food stored in pottery/dishes made outside of the U.S.?			
3.	Does your child live with someone whose job/hobby involves exposure to lead? (i.e., painting, soldering, vehicle repair, automobile battery manufacturing/recycling)			
4.	Has your child ever been anemic and/or had any blood problems?			
5.	Has your child taken any medications from another country?			
6.	Does your child attend day care with anyone with the above risk factors?			

If any of the risk factors are present, your child should be tested for lead. For any questions or information regarding lead consult your local Lead Poisoning Prevention Program at (661)868-0360.

Signature of Person Completing Form:

Staying Healthy Assessment

3 – 4 Years

Child's Name (first & last)	Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	Today's Date	In Child/Day Care? <input type="checkbox"/> Yes <input type="checkbox"/> No
Person Completing Form	<input type="checkbox"/> Parent <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Guardian <input type="checkbox"/> Other (Specify)			Need Help with Form? <input type="checkbox"/> Yes <input type="checkbox"/> 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	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip	
3	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Does your child drink more than one small cup (4 – 6 oz. cup) of juice per day?	No	Yes	Skip	
5	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
6	Does your child play actively most days of the week?	Yes	No	Skip	Physical Activity
7	Are you concerned about your child's weight?	No	Yes	Skip	
8	Does your child watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
9	Does your home have a working smoke detector?	Yes	No	Skip	Safety
10	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
11	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	
12	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	
13	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
14	Do you always stay with your child when she/he is in the bathtub?	Yes	No	Skip	

15	Do you always place your child in a forward facing car seat in the back seat?	Yes	No	Skip	
16	Is the car seat you use the right one for the age and size of your child?	Yes	No	Skip	
17	Do you always check for children before backing your car out?	Yes	No	Skip	
18	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
19	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
20	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
21	Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	Skip	
22	Do you help your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
23	Does your child spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
24	Do you have any other questions or concerns about your child's development, health or behavior?	No	Yes	Skip	Other Questions

If yes, please describe:

<i>Clinic Use Only</i>	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Tobacco Exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/> 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:

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH _____ / _____ / _____
month day year

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer “yes” to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the child sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the child have a long-term health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. If your child is a baby, have you ever been told he or she has had intussusception?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Does the child have a parent, brother, or sister with an immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has the child received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? yes no

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.



48 Month Questionnaire

45 months 0 days
through 50 months 30 days

On the following pages are questions about activities children may do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

Notes:

- Try each activity with your child before marking a response.
- Make completing this questionnaire a game that is fun for you and your child.
- Make sure your child is rested and fed.
- Please return this questionnaire by _____.

COMMUNICATION

YES SOMETIMES NOT YET

1. Does your child name at least three items from a common category? For example, if you say to your child, "Tell me some things that you can eat," does your child answer with something like "cookies, eggs, and cereal"? Or if you say, "Tell me the names of some animals," does your child answer with something like "cow, dog, and elephant"?

2. Does your child answer the following questions? (Mark "sometimes" if your child answers only one question.)

"What do you do when you are hungry?" (Acceptable answers include "get food," "eat," "ask for something to eat," and "have a snack.") Please write your child's response:

"What do you do when you are tired?" (Acceptable answers include "take a nap," "rest," "go to sleep," "go to bed," "lie down," and "sit down.") Please write your child's response:




3. Does your child tell you at least two things about common objects? For example, if you say to your child, "Tell me about your ball," does she say something like, "It's round. I throw it. It's big"?

4. Does your child use endings of words, such as "-s," "-ed," and "-ing"? For example, does your child say things like, "I see two cats," "I am playing," or "I kicked the ball"?

COMMUNICATION (continued)

	YES	SOMETIMES	NOT YET	
5. Without your giving help by pointing or repeating, does your child follow three directions that are <i>unrelated</i> to one another? Give all three directions before your child starts. For example, you may ask your child, "Clap your hands, walk to the door, and sit down," or "Give me the pen, open the book, and stand up."	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. Does your child use all of the words in a sentence (for example, "a," "the," "am," "is," and "are") to make complete sentences, such as "I am going to the park," or "Is there a toy to play with?" or "Are you coming, too?"	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				COMMUNICATION TOTAL ___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child catch a large ball with both hands? (You should stand about 5 feet away and give your child two or three tries before you mark the answer.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
2. Does your child climb the rungs of a ladder of a playground slide and slide down without help?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. While standing, does your child throw a ball <i>overhand</i> in the direction of a person standing at least 6 feet away? To throw overhand, your child must raise his arm to shoulder height and throw the ball forward. (Dropping the ball or throwing the ball underhand should be scored as "not yet.")	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
4. Does your child hop up and down on either the right or left foot at least one time without losing her balance or falling?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your child jump forward a distance of 20 inches from a standing position, starting with his feet together?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. Without holding onto anything, does your child stand on one foot for at least 5 seconds without losing her balance and putting her foot down? (You may give your child two or three tries before you mark the answer.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
				GROSS MOTOR TOTAL ___

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child put together a five- to seven-piece interlocking puzzle? (If one is not available, take a full-page picture from a magazine or catalog and cut it into six pieces. Does your child put it back together correctly?)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

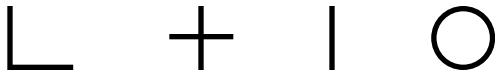
FINE MOTOR *(continued)*

2. Using child-safe scissors, does your child cut a paper in half on a more or less straight line, making the blades go up and down? *(Carefully watch your child's use of scissors for safety reasons.)*



YES	SOMETIMES	NOT YET	_____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

3. Using the shapes below to look at, does your child copy at least three shapes onto a large piece of paper using a pencil, crayon, or pen, without tracing? *(Your child's drawings should look similar to the design of the shapes below, but they may be different in size.)*



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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4. Does your child unbutton one or more buttons? *(Your child may use his own clothing or a doll's clothing.)*

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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5. Does your child draw pictures of people that have at least three of the following features: head, eyes, nose, mouth, neck, hair, trunk, arms, hands, legs, or feet?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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6. Does your child color mostly within the lines in a coloring book or within the lines of a 2-inch circle that you draw? *(Your child should not go more than 1/4 inch outside the lines on most of the picture.)*

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
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FINE MOTOR TOTAL _____

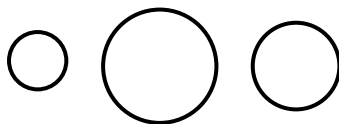
PROBLEM SOLVING

1. When you say, "Say 'five eight three,'" does your child repeat *just* the three numbers in the same order? *Do not repeat the numbers.* If necessary, try another series of numbers and say, "Say 'six nine two.'" *(Your child must repeat just one series of three numbers to answer "yes" to this question.)*

YES	SOMETIMES	NOT YET	_____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

2. When asked, "Which circle is the smallest?" does your child point to the smallest circle? *(Ask this question without providing help by pointing, gesturing, or looking at the smallest circle.)*

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
-----------------------	-----------------------	-----------------------	-------



3. Without your giving help by pointing, does your child follow three different directions using the words "under," "between," and "middle"? For example, ask your child to put the shoe "under" the couch." Then ask her to put the ball "between" the chairs" and the book "in the middle" of the table."

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
-----------------------	-----------------------	-----------------------	-------

4. When shown objects and asked, "What color is this?" does your child name five different colors, like red, blue, yellow, orange, black, white, or pink? *(Mark "yes" only if your child answers the question correctly using five colors.)*

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
-----------------------	-----------------------	-----------------------	-------

PROBLEM SOLVING (continued)

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|-----|
| 5. Does your child dress up and "play-act," pretending to be someone or something else? For example, your child may dress up in different clothes and pretend to be a mommy, daddy, brother, or sister, or an imaginary animal or figure. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. If you place five objects in front of your child, can he count them by saying, "one, two, three, four, five," in order? <i>(Ask this question without providing help by pointing, gesturing, or naming.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| PROBLEM SOLVING TOTAL | | | | ___ |

PERSONAL-SOCIAL

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|-----|
| 1. Does your child serve herself, taking food from one container to another using utensils? For example, does your child use a large spoon to scoop applesauce from a jar into a bowl? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. Does your child tell you at least four of the following? Please mark the items your child knows. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| <input type="radio"/> a. First name <input type="radio"/> d. Last name
<input type="radio"/> b. Age <input type="radio"/> e. Boy or girl
<input type="radio"/> c. City she lives in <input type="radio"/> f. Telephone number | | | | |
| 3. Does your child wash his hands using soap and water and dry off with a towel without help? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. Does your child tell you the names of two or more playmates, not including brothers and sisters? <i>(Ask this question without providing help by suggesting names of playmates or friends.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. Does your child brush her teeth by putting toothpaste on the toothbrush and brushing all of her teeth without help? <i>(You may still need to check and rebrush your child's teeth.)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. Does your child dress or undress himself without help (except for snaps, buttons, and zippers)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| PERSONAL-SOCIAL TOTAL | | | | ___ |

OVERALL

Parents and providers may use the space below for additional comments.

1. Do you think your child hears well? If no, explain: YES NO

OVERALL (continued)

2. Do you think your child talks like other children her age? If no, explain:

 YES NO

3. Can you understand most of what your child says? If no, explain:

 YES NO

4. Can other people understand most of what your child says? If no, explain:

 YES NO

5. Do you think your child walks, runs, and climbs like other children his age?
If no, explain:

 YES NO

6. Does either parent have a family history of childhood deafness or hearing
impairment? If yes, explain:

 YES NO

7. Do you have any concerns about your child's vision? If yes, explain:

 YES NO

OVERALL (continued)

8. Has your child had any medical problems in the last several months? If yes, explain:

 YES NO

9. Do you have any concerns about your child's behavior? If yes, explain:

 YES NO

10. Does anything about your child worry you? If yes, explain:

 YES NO



48 Month ASQ-3 Information Summary

45 months 0 days through
50 months 30 days

Child's name: _____ Date ASQ completed: _____
 Child's ID #: _____ Date of birth: _____
 Administering program/provider: _____

1. SCORE AND TRANSFER TOTALS TO CHART BELOW: See ASQ-3 User's Guide for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	30.72		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	32.78		●	●	●	●	●	●	●	○	○	○	○	○	○
Fine Motor	15.81		●	●	●	○	○	○	○	○	○	○	○	○	○
Problem Solving	31.30		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	26.60		●	●	●	●	●	●	○	○	○	○	○	○	○

2. TRANSFER OVERALL RESPONSES: Bolded uppercase responses require follow-up. See ASQ-3 User's Guide, Chapter 6.

- | | | | | | |
|---|-----|-----------|---|------------|----|
| 1. Hears well?
Comments: | Yes | NO | 6. Family history of hearing impairment?
Comments: | YES | No |
| 2. Talks like other children his age?
Comments: | Yes | NO | 7. Concerns about vision?
Comments: | YES | No |
| 3. Understand most of what your child says?
Comments: | Yes | NO | 8. Any medical problems?
Comments: | YES | No |
| 4. Others understand most of what your child says?
Comments: | Yes | NO | 9. Concerns about behavior?
Comments: | YES | No |
| 5. Walks, runs, and climbs like other children?
Comments: | Yes | NO | 10. Other concerns?
Comments: | YES | No |

3. ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP: You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the child's total score is in the area, it is above the cutoff, and the child's development appears to be on schedule.
 If the child's total score is in the area, it is close to the cutoff. Provide learning activities and monitor.
 If the child's total score is in the area, it is below the cutoff. Further assessment with a professional may be needed.

4. FOLLOW-UP ACTION TAKEN: Check all that apply.

- Provide activities and rescreen in _____ months.
- Share results with primary health care provider.
- Refer for (circle all that apply) hearing, vision, and/or behavioral screening.
- Refer to primary health care provider or other community agency (specify reason): _____
- Refer to early intervention/early childhood special education.
- No further action taken at this time
- Other (specify): _____

5. OPTIONAL: Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						



Community Care Clinics

Southern Sierra Medical Clinic, Southern Sierra Surgical Center, Healthy Bone and Joint

Patient Name: _____ Today's Date: _____

Social Determinants of Health Assessment Tool

To help identify health-related social needs (e.g., food, housing, social isolation, insurance, interpersonal violence, emotional well-being, transportation) in your patients, use this assessment tool to create a social determinants action plan. *Connect your patients with local and state community-based organizations that support social needs by visiting the 211.org website.*

FOOD

YES

NO

1. Within the past 12 months, did you worry your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought not last and you didn't have money to get more?		

HOUSING/UTILITIES

3. Do you have housing?		
4. Do you worry about losing your housing?		
5. Within the past 12 months, have you or your family members you live with been unable to get heat, electricity, water when it was really needed?		

TRANSPORTATION

6. Within the past 12 months, has lack of transportation kept you from going to medical appointments, getting your medicines, non-medical meetings or appointments, work, or from getting things that you need (Food)?		
--	--	--

SAFETY

7. Do you feel physically and emotionally safe where you currently live?		
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by someone?		
9. Within the past 12 months, have you been disgraced or emotionally abused in other ways by your partner or ex-partner?		

HELP NOW

10. Do you have needs that are urgent? For example: I don't have food for today, I don't have a place to sleep tonight, I don't have a ride home or to work, I am afraid I will get hurt if I go home today.		
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Additional Information:

**RIDGECREST REGIONAL HOSPITAL
CLINICS**

TREATMENT CONSENT, PAYMENT AGREEMENT, AND INSURANCE RELEASE AND ASSIGNMENT

THIS AGREEMENT APPLIES TO ALL PATIENTS RECEIVING SERVICES AT REGIONAL HOSPITAL CLINICS -- SOUTHERN SIERRA MEDICAL CLINIC, HEALTHY BONE AND JOINT CENTER, SOUTHERN SIERRA SPECIALTY CENTER, RIDGECREST RURAL HEALTH CLINIC, RIDGECREST URGENT CARE CENTER, TRONA RURAL HEALTH CLINIC, CHINA LAKE COMMUNITY HEALTH CLINIC, AND MOBILE HEALTH CLINIC.

Patient Name: _____ **Birth Date:** _____

1. I consent to the procedures and/or medical services that may be performed during this course of treatment or while I am an outpatient. These may include, but are not limited to, medical or surgical examination, treatment or procedures, including emergency treatment or services if necessary, laboratory tests and procedures, X-ray examinations, telehealth services, anesthesia, photography for medical treatment (using clinic owned camera) or other outpatient hospital and clinic services provided to me under the general and special instructions of my physician or surgeon. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me regarding the result of examination or treatment in this hospital or clinic.
2. I understand that I am under the care and supervision of my attending physician. The hospital or clinic and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital or clinic services provided to me under my physician's general and special instructions.
3. I understand that I am responsible for all charges incurred as a result of such treatment as well as those incurred in collecting for treatment charges. I realize that even though I may have insurance coverage, I am still responsible for payment. If legal action is instituted for payment of such treatment and/or services, I agree to pay reasonable attorney fees and all costs incurred herein.
4. I agree to promptly pay all hospital or clinic bills in accordance with the charges listed in the hospital's or clinic's charge description master and, if applicable, the hospital's or clinic's charity care and discount payment policies and state and federal law. I understand that I may review the hospital's or clinic's charge description master before (or after) I receive services from the hospital or clinic. I understand that physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, and others, may bill separately for their services. If any account is referred to an attorney or collection agency for collection, I will pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate, unless prohibited by law.
5. I authorize the release of any medical information necessary to process my insurance claim.
6. I irrevocably assign and transfer to the hospital and clinics, all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital or clinic of all insurance and health plan benefits payable for outpatient services. I agree that the insurer or plan's payment to the hospital or clinic pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with, and take all steps reasonably requested by, this hospital or clinic to perfect, confirm, or validate this assignment.
7. I authorize the use of this signature on all of my insurance claims submitted for me by the hospital or clinics.
8. I have read or received the Ridgecrest Regional Hospital Summary Notice of Privacy Practices.
9. No one will be able to pick up prescriptions or contact our office regarding my medical attention unless authorized below.

I authorize _____ Relationship _____



**TREATMENT CONSENT, PAYMENT AGREEMENT
AND INSURANCE RELEASE**

HIPAA

- 10. I understand prior to delivery of healthcare via telehealth, Ridgecrest Regional Hospital shall inform the patient about the use of telehealth and I shall give my consent either verbally or written for the use of telehealth as an acceptable mode of delivering healthcare services. I understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audios, video or data communicating. I understand that telehealth also involves the communication of medical information both orally and visually to practitioners located in California or outside of California. I understand that if my treatment is for tele-psych my medical/mental information may be communicated both orally and visually to practitioners in California or outside of California. I understand that I have the right to withhold or withdraw consent at any time. I understand that mental health records shall not be released to me (patient) without written consent. Mental health records shall not be released to the patient or parent if patient is a minor. I agree if the physician agrees to release the records, then all information that may be deemed detrimental to the patients so that they may cause harm to themselves or someone else will be redacted from the records. If a provider disagrees to release records, Ridgecrest Regional Hospital will inform the patient in writing.
- 11. I have read or received the Ridgecrest Regional Hospital E-Prescription Program and hereby provide informed consent to be enrolled in this program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.
- 12. We participate in an Immunization Registry with California Immunization Registry (CAIR), a statewide, confidential database of patient immunization information. The purpose of CAIR is to consolidate immunization information among health care professionals, assure adequate immunization levels, and avoid unnecessary immunizations. Only you, your doctor, or health care workers who can assist you have access to your immunization information. If you do not want your immunization or tuberculosis (TB) screening test records to be shared with other health care providers, agencies, or schools in the CAIR, fill out and submit "Decline or Start Sharing Information Request Form" to CAIR via fax (888-436-8320). The form is available at the CAIR website (<http://cairweb.org/cair-formsl>), or you may contact the CAIR Help Desk (800-578-7889 or CAIRHelpDesk@cdhp.ca.gov), or your health care provider for assistance.
- 13. **CONSENT TO MEDICARE AUTHORIZATION (Medicare Patients Only):** I request that payment of authorized Medicare benefits be made on my behalf to my provider as listed on this letter for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay my claim. If other insurance is indicated on item 9 of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. I understand that I am responsible to pay for the deductible and coinsurance portions of the charges, and for non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Administrative Contractor.
- 14. I agree by providing you my contact information, I authorize you and your associates to contact me at those numbers. This applies to any landline or cell phone number(s) I have provided you. I understand you may contact me by sending text messages or emails, using any email address I provided. I may be contacted by a prerecorded/artificial voice message or an automatic dialing device. I understand providing my phone number(s) is not a condition of receiving services
- 15. I understand that cellphone audio or video recording of patient care activities is not allowed

THIS AUTHORIZATION SHALL REMAIN IN EFFECT FOR ONE (1) YEAR FROM THIS DATE UNLESS REVOKED IN WRITING

Signature of Patient/Guardian: _____ Date: _____

Print Name: _____

If other than Patient, Indicate Relationship: _____

Disclaimer: Please be advised that completing preliminary health and insurance information does not establish a physician-patient relationship with our providers. Ridgecrest Regional Hospital will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the provider will accept you as a patient.



TREATMENT CONSENT, PAYMENT AGREEMENT AND INSURANCE RELEASE