CLINICAS
DEL CAMINO REAL, INCORPORATED

Patient Registration Form

Patient Information

Last Name:	First Name:	Middle:	Nickname:
Social Security Number:		Date of Birth: / /	

Demographics

Home Address: Apt/Space #	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:

Marital Status: ☐Single ☐Married ☐Divorced ☐Legally Separated ☐Widowed ☐Interlocutory ☐Domestic Partner ☐Life Partner

Preferred Language: ☐ English ☐ Spanish ☐ Mixteco ☐ Other:_____	Home Phone Number: ( ) -	Cell Phone Number: ( ) -	Email Address:

Primary Care Provider:

Person Responsible (*Must be an adult over 18 years old)*

Last:	First Name:	Middle:	
Date of Birth: / /	Social Security Number:	Relation to Patient:	
Home Address:	City:	State:	Zip:
Home Phone Number: ( ) -	Cell Phone Number: ( ) -	Email Address:	

Parent/Legal Guardian Information (if the patient is younger than 18 years of age)

Please provide us a copy of any legal documents related to custody or rights to make medical decisions for the care of a minor.

Father's Name	Father's Date of Birth:	Father's Cell Phone Number: ( ) -
Mother's Name	Mother's Date of Birth	Mother's Cell Phone Number: ( ) -

Insurance Information (Please present your insurance card)

Type(s) of Health Care Coverage: Private Insurance Medi-Cal Medicare None Other: _____

Primary:	ID #:	Group #:
Policy Holder Name:		
Relationship to Patient: ☐Self ☐Spouse ☐Parent	Date of Birth:	Social Security Number
Secondary:	ID #:	Group #:
Policy Holder Name:		
Relationship to Patient: ☐Self ☐Spouse ☐Parent	Date of Birth:	Social Security Number

Sexual Orientation (Please answer the following questions in order for us to better serve you.)

Birth Sex:

☐ Male ☐ Female

Gender Identity: (How do you identify?)

☐ Female
☐ Male
☐ Choose not to disclose
☐ Other, please specify: _____
☐ Transgender Woman/Transgender Female/Transfeminine
☐ Transgender Man/Transgender Male/Transmasculine
☐ Genderqueer neither exclusively male nor female

Sexual Orientation:

☐ Heterosexual (straight)
☐ Other, please specify: _____
☐ Bisexual
☐ Choose not to disclose
☐ Lesbian, Gay, Homosexual
☐ Don't know

Patient Registration Form

Housing Status (Please answer the following questions in order for us to better serve you.)

1. Are you living in Public Housing? ☐Yes ☐No

2. Please select one of the options below:

☐ Not Homeless ☐ Doubling up (Living with Friends/Family) ☐ Transitional (Group Home) ☐ Permanent Supportive Housing
☐ Street ☐ Shelter ☐ Other (hotel/motel/day-to-day paid housing) ☐ Unknown

Agricultural Status (Please answer the following questions in order for us to better serve you.)

1. In the last 2 yrs., have you or anyone in your family, worked in any type of agriculture (farm work) like: planting, picking, Preparing the soil, packing house, driving a truck for any type of farm work, worked with animals like cows, chickens, etc.? ☐Yes ☐No
2. In the last 2 yrs., have you or anyone in your family established a temporary home in order to work in any type of agriculture (farm work)? ☐Yes ☐No
3. Have you or a member of your family stopped migrating to work in agriculture (farm work) because of a disability or age? ☐Yes ☐No

Race/Ethnicity

Race (Mark all that are applicable):

☐ American Indian/ Alaskan Native ☐ Filipino ☐ Native Hawaiian ☐ Vietnamese
☐ Asian Indian ☐ Guamanian or Chamorro ☐ Other Asian ☐ White
☐ Black/African American ☐ Japanese ☐ Other Pacific Islander ☐ Choose not to disclose
☐ Chinese ☐ Korean ☐ Samoan

Ethnicity: (Mark all that are applicable):

☐ Mexican/Mexican American/Chicano(a) ☐ Cuban ☐ Not Hispanic, Latino(a) or Spanish Origin
☐ Puerto Rican ☐ Another Hispanic, Latino(a), or Spanish Origin ☐ Choose not to disclose

Veteran Status

1. Are you a U.S. Veteran? ☐Yes ☐No

Family Income *(For Reporting Purposes Only)*

Family Size: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Estimated Annual Household Income: $_____

Pharmacy Information

Primary Pharmacy
Pharmacy Name: _____
Address: _____
City:_____ State: _____ Zip Code:_____
Phone Number:_____
Fax Number: _____

Secondary Pharmacy (if applicable):
Pharmacy Name: _____
Address: _____
City:_____ State: _____ Zip Code:_____
Phone Number:_____
Fax Number: _____

Emergency Contact

Emergency Contact Name:_____

Relationship to Patient:_____

Phone Number (different from primary contact number(s) stated on reverse): ( ) -

How Did You Hear About Us?

Please mark one of the following

☐ Friend/Family Member ☐ Newspaper ☐ Radio ☐ Insurance Referral ☐ Website/ Internet
☐ Billboard ☐ Mailed Advertisement ☐ Other (please specify): _____ ☐ Physician Referral (list name): _____

I hereby consent to any necessary healthcare services and diagnostic tests to assess and treat my health care conditions, which may include prescribed medications issued by the healthcare provider. I understand that even simple treatments or diagnostic measures have a risk of complications. In such cases, further consultation with the provider may be necessary. Clinicas del Camino Real, Inc. will make referrals for specialized services we are unable to provide here.

Date: _____ Name (Print): _____ Signature: _____

CLINICAS
DEL CAMINO REAL, INCORPORATED

OPTICAL HEALTH QUESTIONNAIRE

Patient's Name: _____ Date of Birth: _____

Welcome to Clinicas del Camino Real, Incorporated Optometry department. Please complete the form below to help us better serve your visual needs.

1. What is the reason for your visit? _____
2. When was your last eye exam? _____ With Dr. _____

3.	Do you have any difficulty seeing far?	Y	N	11.	Are you very sensitive to light?	Y	N
4.	Do you have any difficulty seeing up close?	Y	N	12.	Do you see flashes of light or shadows?	Y	N
5.	Do your eyes frequently feel tired?	Y	N	13.	Have you ever had surgery or injury to your eyes?	Y	N
6.	Do you get headaches?	Y	N	14.	Do you currently wear glasses?	Y	N
7.	Are your eyes often red?	Y	N	15.	Do you currently wear contact lenses?	Y	N
8.	Do you see double?	Y	N	16.	Are you interested in contact lenses?	Y	N
9.	Do your eyes frequently itch?	Y	N	17.	Are you interested in Lasik refractive surgery?	Y	N
10.	Do you experience pain in or around your eyes?	Y	N				

MEDICAL HISTORY

1. Describe your general Health: _____

2.	Are you taking any medications?	Y	N	If so, please explain:
3.	Are you allergic to any medications?	Y	N	If so, which ones?
4.	Do you smoke?	Y	N	If so, how many per day?

5. Are you currently pregnant? Y N
6. Are you currently nursing? Y N

7. Do YOU have any of the following:

Glaucoma	Y	N
High Blood Pressure	Y	N
Heart Disease	Y	N
Diabetes	Y	N
Arthritis	Y	N
Cataracts	Y	N
Sinus Conditions	Y	N
Epilepsy	Y	N
T.B.	Y	N
Hepatitis	Y	N
Thyroid Condition	Y	N
Any Communicable disease	Y	N
Macular degeneration	Y	N
Cancer	Y	N

8. Does anyone in your FAMILY (Blood relative) have:

Glaucoma	Y	N	If yes, please explain who? _____
High Blood Pressure	Y	N	If yes, please explain who? _____
Heart Disease	Y	N	If yes, please explain who? _____
Diabetes	Y	N	If yes, please explain who? _____
Arthritis	Y	N	If yes, please explain who?
Cataracts	Y	N	If yes, please explain who?
Blindness	Y	N	If yes, please explain who?
Eye Turn In or Out	Y	N	If yes, please explain who? _____
Macular Degeneration	Y	N	If yes, please explain who? _____

Comments: _____

X _____ X _____
Patient Signature Date

CLINICAS del Camino Real, Incorporated

OPTOMETRY DEPARTMENT

INFORMED CONSENT FOR PUPIL DILATION

Dilation of your eyes is extremely important in order to thoroughly examine the back and periphery. Without dilation, the doctor only sees a small portion of the back of the eye. By increasing the pupil size through dilating drops, the doctor can better view the inside of the eye for detection of cataracts, floaters, hypertensive or diabetic retinal changes, and other retinal diseases and abnormalities. Dilation requires 2 or 3 drops in each eye and takes 20 – 30 minutes to dilate your pupils.

The following known risks and complications incident to or reasonably to be anticipated in connection with pupil dilation are:

1. Distance vision might be slightly blurred
2. Near reading vision might be blurred for 3 to 4 hours
3. Sensitivity to light (disposable sunglasses are provided to make you more comfortable)

You may wish to re-schedule the dilation procedure if you are returning to work or would feel more comfortable bringing someone to drive you home.

PLEASE INDICATE YOUR PREFERENCE:

☐ I agree to have my eyes dilated.
☐ I decline having my eyes dilated.

DEPARTAMENTO DE OPTOMETRÍA

AVISO DE CONSENTIMIENTO PARA LA DILATACIÓN DE LA PUPILA

La dilatación de la pupila de sus ojos es extremadamente importante para poder examinar completamente la parte de atrás y la parte periferia. Sin la dilatación, el doctor puede ver solamente una pequeña parte de atrás del ojo. Al aumentar el tamaño de la pupila por medio de gotas para dilatación, el doctor puede ver mejor la parte interior del ojo para detectar cataratas, flotantes, o cambios hipertensivos o de retina diabética, y otras anormalidades y enfermedades de la retina. La dilatación requiere de 2 a 3 gotas en cada ojo y se toma de 20 – 30 para dilatarle sus pupilas.

Los siguientes riesgos e incidentes de complicaciones conocidos de o razonablemente anticipados en conexión con la dilatación de las pupilas son:

1. La visión de lejos puede ser un poco borrosa;
2. La visión para leer de cerca puede ser un poco borrosa de aproximadamente 3 a 4 horas;
3. Sensibilidad a la luz (le proporcionamos lentes desechables para el sol para que se sienta más cómodo/a)

Tal vez usted quiera hacer otra cita para el procedimiento de la dilatación de las pupilas si es que usted tiene que regresar al trabajo, o si se siente más confortable trayendo a otra persona para que la lleve de regreso a su casa.

POR FAVOR INDIQUE SU PREFERENCIA:

☐ Estoy de acuerdo que se me haga la dilatación de mis ojos.
☐ Me niego a que se me haga la dilatación de mis ojos.

_____ _____

Signature of patient or parent/legal guardian
Firma del paciente/padre/guardián

Date/Fecha

_____ _____

Signature of witness
Testigo

Date/Fecha

CLINICAS
DEL CAMINO REAL, INCORPORATED

Patient Name: _____

MR #: _____

Optometry Appointment Policy

Dear Patient:

When you make an appointment with your optometrist, the time is reserved exclusively for you. If you fail to show up, the appointment time is lost. Clinicas del Camino Real, Incorporated has an Optometry Appointment Policy in an effort to ensure access for all our optometry patients. This includes the following:

1. You must cancel or reschedule your optometry appointment at least 24 hours in advance. Without a 24 hour notice, the appointment is considered a failed appointment.

2. If you are late, your appointment may be cancelled and/or rescheduled for another day. If the optometrist's schedule allows, you may wait to be seen as a "walk-in" (patient without an appointment).

3. If you are a new patient, you will receive a phone call to confirm your appointment 1 week before your appointment date. If you are an established patient you will receive a phone call 48 hours before your appointment date. **In order for the appointment to be considered confirmed, you MUST speak to a Clinicas representative directly and confirm that you will be attending.**

   IMPORTANT:

   Due to the large number of patients waiting for an optometry appointment, if you fail to confirm that you will be coming to your appointment, your reserved appointment time will be given to another patient. At that time, you will have the following options: (1) be seen as a walk-in (if time optometrist's schedule allows) or (2) reschedule your appointment.

Your signature confirms that you have read and understand this policy.

_____	_____	_____
Signature (*If minor, parent signature*)	Relation to patient	Date

CLINICAS del Camino Real, Incorporated

Patient's Learning Needs Assessment

Patient's Name:_____ Date:_____

We would like to know about your learning preferences so we can make sure we are meeting your needs. Your responses are directly responsible for improving these services. Thank you for your time.

1. Circle highest year of school completed:

   N/A None 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17+
   (Primary) (High School) (College / University)

2. What language do you prefer to speak?

   ☐ English ☐ Spanish ☐ Other: _____

3. What language do you prefer to read?

   ☐ English ☐ Spanish ☐ Other: _____

4. Which of the following best describes how you read:

   ☐ Like to read & read often ☐ Can read but do not read often

   ☐ Do not like to read ☐ Do not know how to read

5. How do you prefer to learn new things? (check all that apply)

   ☐ Reading (pamphlets, books) ☐ Listening to audio tapes

   ☐ Practicing new skills following a demonstration ☐ Viewing films / videos

   ☐ Attending individual education sessions ☐ Attending group classes

   ☐ Using instructional illustrations, posters, pictures, flip charts

   ☐ Other:_____

6. Do you have any mental, emotional, or physical conditions that may affect the way you learn?

   ☐ No ☐ Yes

CLINICAS
DEL CAMINO REAL, INCORPORATED

Patient's Name_____ Chart #_____
(Nombre del Paciente) (Numero de Expediente)

Acknowledgement of Receipt of Clinicas Del Camino Real, Inc.'s Privacy Practices Notice, Advance HealthCare Directives information and Patient Portal Instructions.

I,_____have received a copy of Clinicas Del Camino Real, Inc. Privacy Practices Notice, Advance HealthCare Directives information, and Patient Portal Instructions.

_____ _____
Signature Date

Reconocimiento de Recibo de Aviso de las Prácticas de Privacidad de Clínicas del Camino Real, Inc., Directiva Anticipada de Atención de la Salud, e Instrucciones del Portal del Paciente.

Yo,_____reconozco que he recibido una copia del Aviso de las Practicas de Privacidad de Clinicas del Camino Real, Inc., información sobre Directiva Anticipada Atención de la Salud, e Instrucciones del Portal del Paciente.

_____ _____
Firma Fecha

Staff Use Only/Para Uso de Oficina Solamente:

If the Privacy Practices Notice, Patient Portal Instructions, and Advance HealthCare Directives information was not given to the patient or the patient's legal representative, please indicate the reason why below:

Right to Amend
You can ask us to correct health information about you that you think is incorrect or incomplete by submitting a *Medical Record Amendment Form* to be made a part of your medical record. You will receive a copy of this form and a response will be provided to you no later than 60 days of receipt. We may deny your request to amend or correct your records. If your request is denied, we will provide you a written denial including the reason for the denial. You have the right to submit a written statement disagreeing with the denial.

Right to Request Confidential Communications
You can ask that we communicate with you in a specific way (for example, home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.

Right to Request Restrictions
You can ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree with your request, and we may deny if we have reason to believe it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will approve unless a law requires us to share that information.

Right to an Accounting of Disclosures
You can ask for a list (accounting) of the times we've shared your health information, who we shared it with, and why. We will include all the disclosures for six years prior to the date you ask, except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but may charge a reasonable, cost-based fee if you ask for another one within 12 months.

Right to a Paper Copy of This Notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Right to Choose Someone to Act for You
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

Right to Submit a Complaint
You can complain if you feel we have violated your rights by contacting the Clinicas Privacy Officer at 1040 Flynn Road, Camarillo C.A., 93012, calling (805) 659-1740, fax: (805) 659-9959, or emailing compliance@clinicas.org.

You may also file a complaint directly with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting https://www.hhs.gov/hipaa/filing-a-complaint/index.html. We will not retaliate against you for filing a complaint.

YOUR CHOICES
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care by completing a *Consent to Release Health Information to Individuals/Family Members Form*
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

CLINICAS
DEL CAMINO REAL, INCORPORATED

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.

Clinicas del Camino Real, Inc. (Clinicas) is committed to providing quality healthcare services to you. An important part of that is protecting your medical information according to applicable law. If you have any questions about this notice, please ask to speak to the Privacy Officer or visit any of the Clinicas del Camino Real, Inc. locations.

YOUR RIGHTS
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Right to Inspect and Copy
You have the right to inspect and obtain a copy your health information, in the format that you request. You must submit a written request in order to inspect or copy your health information. We may charge a reasonable cost-based fee. We will provide a copy or a summary of your health information, usually within 15 days of your request. We may deny your request in certain limited circumstances.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

For Treatment
We can use your health information and share it with other professionals who are treating you. For example, a doctor treating you for an injury asks another doctor about your overall health condition.

For Payment
We can use and share your health information to bill and get payment from health plans or other entities. For example, we will give information about you to your health insurance plan so it will pay for your services.

For Operations
We can use and share your health information to run our practice, improve your care, and contact you when necessary. For example, we use health information about you to manage your treatment and services.
Appointment Reminders: We may contact you to remind you that you have an appointment.
Health-Related Products and Services: We may tell you about health-related products or services that may be of interest to you.

Organized Health Care Arrangement (OHCA)
Clinicas del Camino Real is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants can be requested on their website at <http://www.ochin.org>www.ochin.org. The request form is available here: https://ochin.org/member-request/. As a business associate of Clinicas del Camino Real, OCHIN supplies information technology and related services to Clinicas del Camino Real and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and access clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by Clinicas del Camino Real with other OCHIN participants when necessary for health care operation purposes of the organized health care arrangement.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Public Health Risks
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do Research
We can use or share your information for health research.

Comply with the Law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to Organ and Tissue Donation Requests
We can share health information about you with organ procurement organizations.

Work with a Medical Examiner or Funeral Director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address Workers' Compensation, Law Enforcement, and Other Government Requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to Lawsuits and Legal Actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site at www.clinicas.org

What happens when someone else makes decisions about my treatment?

The same rules apply to anyone who makes healthcare decisions on your behalf – a healthcare agent, a surrogate whose name you gave to your doctor, or a person appointed by the court to make decisions for you. All are required to follow your **Health Care Instructions** or, if none, your general wishes about treatment, including stopping treatment. If your treatment wishes are not known, the surrogate must try to determine what is in your best interest.

The people providing your health care must follow the decisions of your agent or surrogate unless a requested treatment would be bad medical practice or ineffective in helping you. If this causes disagreement that cannot be worked out, the provider must make a reasonable effort to find another healthcare provider to take over your treatment.

Will I still be treated if I don't make an advance directive?

Absolutely. You will still get medical treatment. We just want you to know that if you become too sick to make decisions, someone else will have to make them for you. Remember that:

• A **Power of Attorney for Health Care** lets you name an agent to make decisions for you. Your agent can make most medical decisions – not just those about life sustaining treatments – when you can't speak for yourself. You can also let your agent make decisions earlier, if you wish.

• You can create an **Individual Healthcare Instruction** by writing down your wishes about health care or by talking with your doctor and asking the doctor to record your wishes in your medical file. If you know when you would or would not want certain types of treatment, an **Instruction** provides a good way to make your wishes clear to your doctor and anyone else who may be involved in deciding about treatment on your behalf.

How can I get more information about making an advance directive?

Ask your doctor, nurse, social worker, or healthcare provider to get more information for you. You can have a lawyer write an advance directive for you, or you can complete an advance directive by filling in the blanks on a form.

CLINICAS
DEL CAMINO REAL, INCORPORATED

YOUR RIGHT TO MAKE DECISIONS ABOUT MEDICALTREATMENT

This brochure explains your right to make healthcare decisions and how you can plan now for your medical care if you are unable to speak for yourself in the future.

A federal law requires us to give you this information. We hope this information will help increase your control over your medical treatment.

SF900-E

The right to choose your primary care provider

As a patient of Clinicas del Camino Real, Incorporated (Clinicas) we will ensure that you have access to quality health care that is appropriate for your specific needs. You are guaranteed the right to choose your Primary Care Provider (PCP). In the event that you are not completely satisfied with your active PCP within Clinicas you have the right to request another PCP. Your request will be reviewed and all feasible attempts will be made to accommodate your request.

Who decides about my treatment?

Your doctors will give you information and advice about treatment. You have the right to choose. You can say "Yes" to treatments you want. You can say "No" to any treatment that you don't want – even if the treatment might keep you alive longer.

How do I know what I want?

Your doctor must tell you about your medical condition and about what different treatments and pain management alternatives can do for you. Many treatments have "side effects." Your doctor must offer you information about problems that medical treatment is likely to cause you.

Often, more than one treatment might help you – and people have different ideas about which is best. Your doctor can tell you which treatments are available to you, but your doctor can't choose for you. That choice is yours to make and depends on what is important to you.

Can other people help with my decisions?

Yes. Patients often turn to their relatives and close friends for help in making medical decisions. These people can help you think about the choices you face. You can ask the doctors and nurses to talk with your relatives and friends. They can ask the doctors and nurses questions for you.

Can I choose a relative or friend to make healthcare decisions for me?

Yes. You may tell your doctor that you want someone else to make healthcare decisions for you. Ask the doctor to list that person as your healthcare "surrogate" in your medical record. The surrogate's control over your medical decisions is effective only during treatment for your current illness of injury or, if you are in a medical facility, until you leave the facility.

What if I become too sick to make my own healthcare decisions?

If you haven't named a surrogate, your doctor will ask your closest available relative or friend to help decide what is best for you. Most of the time that works. But sometimes everyone doesn't agree about what to do. That's why it is helpful if you can say in advance what you want to happen if you can't speak for yourself.

Do I have to wait until I am sick to express my wishes about health care?

No. In fact, it is better to choose before you get very sick or have to go into a hospital, nursing home, or other healthcare facility. You can use an **Advance Health Care Directive** to say *who* you want to speak for you and *what* kind of treatments you want. These documents are called "advance" because you prepare one before healthcare decisions need to be made. They are called “directives” because they state who will speak on your behalf and what should be done.

In California, the part of an advance directive you can use to appoint an agent to make healthcare decisions is called a **Power of Attorney for Health Care**. The part where you can express what you want done is called an **Individual Health Care Instruction.**

Who can make an advance directive?

You can if you are 18 years or older and are capable of making your own medical decisions. You do not need a lawyer.

Who can I name as my agent?

You can choose an adult relative or any other person you trust to speak for you when medical decisions must be made.

When does my agent begin making my medical decisions?

Usually, a healthcare agent will make decisions for you only after you lose the ability make them yourself. But, if you wish, you can state in the **Power of Attorney for Health Care** that you want the agent to begin making decisions immediately.

How does my agent know what I would want?

After you choose your agent, talk to that person about what you want. Sometimes treatment decisions are hard to make, and it truly helps if your agent knows what you want. You can also write your wishes down in your advance directive.

What if I don't want to name an agent?

You can still write out your wishes in your advance directive, without naming an agent. You can say that you want to have your life continued as long as possible. Or you can say that you would not want treatment to continue your life. Also, you can express your wishes about the use of pain relief or any other type of medical treatment.

Even if you have not filled out a written **Individual Health Care Instruction**, you can discuss your wishes with your doctor, and ask your doctor to list those wishes in your medical record. Or you can discuss your wishes with your family members or friends. But it will probably be easier to follow your wishes if you write them down.

What if I change my mind?

You can change or cancel your advance directive as long as you can communicate your wishes. To change the person you want to make your healthcare decisions, you must sign a statement or tell the doctor in charge of your care.

CLINICAS
DEL CAMINO REAL, INCORPORATED

Accessing Your Health Information Using the

CLINICAS PATIENT PORTAL

COMMUNICATE & COLLABORATE

Communicate securely with your care teams to ask and resolve questions.

VIEW YOUR LAB RESULTS

Access most of your lab results as soon as they are ready.

MEDICATION REFILL REQUESTS

Medication refills are as easy as a click of a button.

CLINICAS PORTAL INSTRUCTIONS

It only takes a moment to register for the Clinicas del Camino Real, Inc. (Clinicas) patient portal. You will receive a PIN number via text message and/or email. If you cannot locate your PIN, please call (805) 647-6353 to obtain another one.

How you enroll depends on whether you are a new user of the Clinicas Patient Portal (either as a patient or a person authorized by a patient) or have previously registered (either as a patient or a person authorized by a patient).

- ✓ If you have NEVER registered to the Clinicas Patient Portal as a patient or an authorized person for a patient, follow instructions # 1
- ✓ If you have already enrolled in the Clinicas Patient Portal as a patient or authorized person for a patient, follow instructions # 2

1 Follow if you are NEW to the Clinicas portal and are a PATIENT or a PROXY (person authorized by patient to access their health information)

- Access portal by one of the following options:
  - o Click on the link that was sent to you via text message and/or email.
  - o Open a browser and go to https://patientportal.clinicas.org
- If you connected using the website, click on "**Create a New Account**"
- If you connected using the link sent to you via text or email message, click "**Let's Get Started**"
- Review the Terms & Conditions and scroll to the bottom of the screen (***Please note***: *The Terms & Conditions are in English, followed by the Spanish version*).
  - o Scroll to the bottom of the screen, check the box next to "**I verify I am at least 18 years of age**"
  - o Click "**I Accept"**
- When asked if you have a pin, click "**Yes**".
- Enter your **PIN** number and click "**Next**" (if you followed text or email link, the PIN number will auto-populate)
- Read the Confirm Identity message and click "**Next**"
- Enter and confirm your email address and click "**Next**"
- Create a user name by following the on-screen instructions and click "**Next**"
- Create a password by following the on-screen instructions and click "**Next**"
- Choose a security question, provide an answer and click "**Next**".
- You're all set!
  - o Take a "**tour**" (found on top right-hand corner under your name) or go to the home page.
  - o Download the App for **iOS** or **Android**

2 Follow if you are ALREADY ENROLLED on the Clinicas Patient Portal (as a patient or an authorized person for another patient) and will also be an authorized person for the patient being enrolled.

- Have the text message or email invite available including the patient's PIN number
- Open a browser and go to https://patientportal.clinicas.org
- Enter your user name and password and click "**Log In**"
- Click on the down-arrow next to the patient name on the top left-hand side of the screen.
- Click on "**Connect With New Patient**"
- Enter the patient's PIN
- Read the Confirm Identity message and click "**Next**"
- Complete the Challenge Questions by entering the patient's **first name**, **last name** and **date of birth**. Click "**Next**"
- Verify the patient's demographic information and click "**Next**"
- You're all set! You can now view the patient's health information.

Some exclusions apply for seeing lab results. Patients ages 12-17 will not have access to the portal.

CLINICAS del Camino Real, Incorporated

FINANCIAL POLICY

MR#_____

Thank you for choosing Clinicas del Camino Real, Inc. (CDCR) as your health care provider. We are committed to providing caring and professional health care services to all of our patients. As part of the delivery of services, we have established a financial policy which is designed to clarify payment policies of our practice. The person responsible for payment is required to read and sign this form.

PAYMENT

Full payment is due at time of service. We accept cash, checks and credit cards (Visa, Mastercard, Discover, American Express). There is a $50 fee for all returned checks. The adult accompanying a minor (or guardian of the minor) is responsible for full payment.

SPECIAL PROGRAMS

You may be enrolled to special programs to assist in lowering cost of services. You will be responsible for payment for any non-covered service.

INSURANCE

All patients must provide valid and up-to-date proof of insurance coverage. Please notify us of any changes in insurance coverage prior to time of service.

We participate in most insurances but it is your responsibility to check if we are covered by your specific insurance plan. We will bill your insurance as a courtesy service to you. The person responsible for payment of services will be sent a bill for any remaining balance not paid by the insurance including services denied as not reasonable or necessary or not covered. Your insurance policy is a contract between you and your insurance company so you will have to contact them to dispute any payment denials.

USUAL AND CUSTOMARY RATES

We charge clients what is usual and customary for our area. You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates.

BALANCE POLICY

A balance statement will be mailed and payment in full is due upon receipt of this statement. Any balances 120 days past due will be referred to a collection agency and/or credit bureau. The Agency will incur interest charges which will be payable to the agency. In cases of divorce or separated parents, it will be the guarantor's responsibility to pay any balances. Clinicas will not participate in disputes between custodial or non-custodial parents.

APPOINTMENTS

Help us serve you better by keeping scheduled appointments. If you are unable to keep it, please contact us to reschedule at least 24 hours before your appointment.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT BENEFITS

I hereby authorize CDCR, Inc. to release any information necessary to my insurance carriers regarding my treatment and condition that is necessary to determine plan benefits and to process payment for insurance claims. I authorize payment of services directly to CDCR, otherwise payable to me.

I have read, understand and agree with the Financial Policy.

X_____ X_____

PRINTED name of Person responsible for payment

Signature of patient or Person responsible for payment & DATE

CLINICAS
DEL CAMINO REAL, INCORPORATED

Patient Name: _____

MR #: _____

CONSENT TO RELEASE HEALTH INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

The state of California mandates that health information be shared only with the patient or the patient's legal representative. In accordance with this law, every employee of Clinicas del Camino Real, Inc. is required to sign a Confidentially Statement on an annual basis indicating that they will keep the health information of every patient in the strictest confidence.

The staff and/ or physicians cannot release health information to family members of patients without permission from the patient or the patient's legal representative.

In order to authorize our providers and personnel to verbally release general health information to individuals/family members, please list the name(s), phone number and relationship of those individuals in the space provided below.

General information excludes the discussion of sexually transmitted diseases, HIV (AIDS Virus) testing and/or results, pregnancy related services, drug and alcohol counseling, and psychiatric / mental health services.

Name:_____ Phone: _____ Relationship:_____

Name:_____ Phone: _____ Relationship:_____

Name:_____ Phone: _____ Relationship:_____

☐ I **do not** authorize Clinicas del Camino Real, Inc. to release any information concerning my health care to any individual.

I authorize Clinicas del Camino Real, Inc. to verbally release general health information to the above named individual(s). This authorization will supersede any previous authorization(s) to verbally release general health information.

_____ _____
Signature of patient or legally authorized individual Date

_____ _____
Witness Date

Revised: January 14, 2020

CLINICAS
DEL CAMINO REAL, INCORPORATED

Patient Name: _____

DOB: _____ MR#: _____

ELECTRONIC COMMUNICATION CONSENT FORM

Clinicas del Camino Real, Inc. (Clinicas) is pleased to provide additional ways to communicate with its patients by providing access to their medical records through the new Patient Portal and/or the Appointment Confirmation System. We will need your consent in order to send you email or text message notifications relating to the patient portal/appointment confirmation system. ***Please note that portal access and appointment confirmation system is not available for patients ages 12-17.***

For each section, please indicate whether you consent or decline:

PATIENT PORTAL (You will receive e-mail and/or text message notifications)

☐	I consent to participate in Patient portal.	☐	I decline to participate in Patient portal.

_____ I want to grant access to the following person to have access to my patient portal.

First/Last Name: _____ Cell Phone: ( ) - _____
DOB: _____ Email: _____
Relationship: _____

APPOINTMENT CONFIRMATION SYSTEM (You'll receive text message only)

☐	I consent to participate in Appointment Confirmation System.	☐	I decline to participate in Appointment Confirmation System.

I understand that I am responsible for informing Clinicas in writing of any changes in cell phone number and email address. I understand that Clinicas del Camino Real, Inc. does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

I understand that text and email messaging is not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text/email may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in text messages may include your first name, date/time of appointments, name of physician, and physician phone number, or other pertinent information.

_____ _____
Patient/Guarantor Signature Date

For Office Use Only

(Patient Portal Proxy's Only): Proxy name and information must be manually added in Staff Portal in order to send a portal invite. Employee name and date confirms this task has been done.

_____ _____
Staff Name *Date*

Revised 9/5/2019