1. ¿Tiene actualmente a ha tenido en los últimos 14 días, uno de los siguientes síntomas?

Fiebre (100.4 °F o mas)	Si	No
Tos	Si	No
Dificultad para respirar	Si	No
Dolores de musculo o cuerpo	Si	No
Perdida reciente de olor o de sabor	Si	No
Nauseas o vómitos	Si	No
Diarrea	Si	No
Cansancio, además de otros síntomas	Si	No
Dolor de cabeza, además de otros síntomas	Si	No
Dolor de garganta, además de otros síntomas	Si	No
Congestion o secreción nasal, además de otros síntomas	Si	No

2. ¿Está usted o un miembro de su hogar autoaislamiento, esperando los resultados de una prueba para el COVID-19, o se le ha pedido a usted o a un miembro de su hogar que se auto aislé?

Si No

3. ¿En las ultimas dos semanas, ha recibido usted o alguien en su hogar un resultado positive para COVID-19 y se le ha informado que debe permanecer en casa?

Si No

Mission Statement

Our mission is to promote a culture of life by improving the physical, spiritual and social health of the community. In doing so, we strive to offer the highest quality of compassionate, personalized medical care to all of our patients and clients.

Our ethical guideposts are traditional Christian teachings as set forth by the Catholic Church. We seek to promote and to protect the sanctity of life from the moment of conception until the time of natural death. We acknowledge the dignity of all people and support the basic building block of society, the family.

In supporting life and respecting God's design for human procreation, we offer instruction in the very effective form of natural planning called the Creighton Model of Fertility Care. We also offer NaPro Technology treatments which are aimed at correcting underlying defects in the female reproductive system.

Because of our ethical and moral foundations, we do not prescribe or refer for abortion, contraception, sterilization procedures or euthanasia. We only prescribe erectile devices to men married to women.

We realize that all people may not agree with our mission or our ethical beliefs and we respect their right to disagree. Our refusal to provide certain services that are widely available elsewhere is not intended to be a judgement of others on our part. Rather, this is simply what we are able to offer in good conscience.

I have had an opportunity to review the mission statement.

Signature: _____ *Date:*_____

Culture of Life
Family Health Care

Cuestionario Para Visita Medica

Antes de ser visto por el proveedor, favor de llenar el siguiente questionario.

Nombre del Paciente: _____ Fecha: _____

Esta usted experimentando alguno de lo siguiente?

Sintomas:	Si	No
General		
Perdida de peso excessivo		
Fiebre		
Alergía		
Reacción alergica a medicamento		
Problemas de Ojos,Oidos,Nariz,o Garganta		
Problemas nuevos con la visión		
Dolor de garganta		
Problemas Endocrinos		
Sudoración excesiva		
Intolerancia al frio		
Respiratorio		
Tos		
Sonido de pecho		
Dificultad para respirar		
Pecho		
Masa o nódulos mamarios		
Secreción del pezón		
Corazón		
Dolor de pecho		
Palpitaciónes		
Abdomen		
Dolor Abdominal		
Hematologia		
Anemia		
Problemas Urinarios		
Dolor al orinar		
Ortopédico		
Dolor en las articulaciones		
Inflamación de articulaciones		
Neurología		
Dolor de cabeza		
Hormigueo/Entumecimiento		
Pérdida de fuerza		
Psicología		
Humor depressivo		
Ansiedad o panico		
Mujeres Solamente		
Períodos irregulares		
Sin Periodos		

Name: _____

Age: _____ DOB: _____Date: _____

COLFS Medical Clinic
A Holistic Approach to Healthcare

Pediatric TB Exposure Risk Assessment

Please answer the following questions by checking the appropriate box:
Por favor de contestar a las siguientes preguntas marcando la respuesta adecuada:

1.	Has a family member or anyone the child sees regularly been diagnosed or suspected sick with active TB disease? *¿Algún miembro de la familia o alguien que el niño(a) frecuenta ha sido diagnosticado o se sospecha de ser enfermo con tuberculosis activo?*	☐ Yes/Si ☐ No
2.	Has the child had symptoms of TB such as cough, chest congestion, fever, night sweats and/or weight loss? *¿Ha tenido síntomas el niño(a) de la tuberculosis tales como tos, congestión de pecho, fiebre, sudor en las noches y/o pérdida de peso?*	☐ Yes/Si ☐ No
3.	Was the child born in or travel to high TB prevalence countries (most countries from Asia, Africa, Latin America and parts of Eastern Europe)? *¿El niño(a) es nacido o viaja frecuentemente a países altamente expuestos a la tuberculosis?*	☐ Yes/Si ☐ No
4.	Does the child live in out of home placements (such as board & care or residential facilities)? *¿El niño(a) vive en colocaciones caseras (tales como casa de huéspedes o instalaciones residenciales)?*	☐ Yes/Si ☐ No
5.	Does the child have an HIV infection or other immunosuppressive condition? *¿El niño(a) tiene la infección de VIH u otra condición inmunosupresora?*	☐ Yes/Si ☐ No
6.	Does the child live with someone with HIV? *¿El niño(a) vive con alguien con VIH?*	☐ Yes/Si ☐ No
7.	Does the child live or frequently visit with persons who have been incarcerated in the last 5 years? *¿El niño(a) vive o visita con frecuencia a alguien que fue encarcelado en los últimos 5 años?*	☐ Yes/Si ☐ No
8.	Does the child have family members or frequent visitors who were born in high TB prevalence countries (most countries from Asia, Africa, Latin America and parts of Eastern Europe)? *¿Tiene el niño(a) miembros de familia o invitados nacidos en países altamente expuestos a la tuberculosis?*	☐ Yes/Si ☐ No
9.	Has the child lived among or been frequently around individuals who are homeless, migrant workers, users of street drugs or residents in nursing homes? *¿El niño(a) vive entre o frecuenta a individuos sin hogar, trabajadores emigrantes, usuarios de drogas o residentes en clínicas de reposo?*	☐ Yes/Si ☐ No

*****TO BE COMPLETED BY THE MEDICAL STAFF/ PARA SER COMPLETADO POR EL PERSONAL MEDICO*****

Administer the Mantoux TB skin test to all children who have any of the above risk factors (indicated by a Yes response) UNLESS,

1. The child has a previously documented positive Mantoux TB skin test, or
2. The child has had a TB skin test within the last 12 months, or
3. The child has been vaccinated with BCG within the last 12 months.

Reason for TB skin test if other than periodic evaluation:

☐Work ☐School ☐TB Contact ☐Prenatal ☐Other, Specify: _____

Note: Only trained licensed personnel, not parents or guardians may read/interpret the skin test.

Nurse/Provider Signature: _____ Date: _____

Culture of Life Family Health Care
COLFS Medical Clinic
A Holistic Approach to Healthcare

REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this persona patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance]
❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ Welfare *(Please provide coupon)* ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

Políticas de la Oficina

Nos esforzamos por ofrecer atención de la mejor calidad a nuestros pacientes. Para satisfacer las necesidades de todos, hemos establecido varias políticas.

Tenga en cuenta lo siguiente:

1. Todos los copagos y pagos del paciente deben ser colectados el día de su visita.
2. Se debe proporcionar la información completa sobre su seguro, su historial médico, su dirección y su número de teléfono.
3. Los formularios individuales (WCC, exámenes físicos, etc.) deben completarse antes de entrar con el proveedor. Appointments will be rescheduled for late arrivals.
4. Si llega tarde, su cita sera reprogramada.
5. Se aplicará un cargo por cancelación de $ 45.00 dlls por citas canceladas o perdidas sin previo aviso de 24 horas.
6. Para proteger la privacidad de todos nuestros pacientes, solo se permite una persona en la recepción. Tome asiento y espere hasta que lo llamen
7. Si su seguro niega un reclamo médico, usted será responsable de todos los cargos.

Gracias por su consideración.

Al firmar este formulario de consentimiento, acepto los términos y políticas enumerados anteriormente.

Nombre del Paciente y Firma: _____ Fecha:_____

AUTHORIZATION FOR MEDICAL TREATMENT AND FINANCIALRESPONSIBILITY

COLFS Medical Clinic
A Holistic Approach to Healthcare

Patient Name: _____ **DOB:** _____

1. CONSENT

I authorize my physician and other physicians who may attend me, their assistants, including those employed by the Culture of Life Family Health Care or COLFS Medical Clinic to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my physician. These services may includepathology, radiology, emergency services and other special services ordered by my physician(s). In consenting to treatment, I have not relied on any statements as to results.

In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C and HIV.

2. MEDICARE/TRICARE INSURANCE BENEFITS

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize the release of medical or other information to the Medicare Program or its Intermediaries or carriers concerning this, or a related claim filed by Culture of Life Family Health Care or COLFS Medical Clinic. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for the Part B deductible for each year and/or visit, the remaining co-insurance and any other non-covered personal charges.

I (or my representative) certify that I (or he/she) have read (or if the patient/representative is unable to read has had the form read to him/her) and understand, accepts the above and further certify that I am the patient, or am duly authorized on behalf of the patient to execute such an agreement.

3. GUARANTEE FOR PAYMENT

In accordance with the above terms and in consideration of the services provided to the above-named patient by Culture of Life Family Health Care or COLFS Medical Clinic, the undersigned agrees, whether he/she signs as patient or guarantor, to pay Culture of Life Family Health Care or COLFS Medical Clinic for all services ordered by the attending physician or requested by the patient and/or the patient's family. If the requirements for referral, second opinion or pre-certification of care, as outlined by my insurer, benefit plan or other payer, have not been followed, the patient and/or guarantor may in some instances be personally responsible for all charges incurred.

COLFS
Medical Clinic
A Holistic Approach to Healthcare

4. ASSIGNMENT OF INSURANCE BENEFITS

In consideration of any and all medical services, care, drugs, supplies, equipment and facilities furnished by Culture of Life Family Health Care or COLFS Medical Clinic, all attending physicians, I authorize direct payment to Culture of Life Family Health Care or COLFS Medical Clinic of all insurance benefits applicable to these medical services, which are now, or which shall become due and payable to me.

.

HIPAA – Notice of Privacy Practices Acknowledgement

I acknowledge that I have received, or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practice" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that Culture of Life Family Health Care or COLFS Medical Clinic, the physicians, the nurses and other COLFS staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern Culture of Life Family Health Care or COLFS Medical Clinic operations and responsibilities.

Initials of patient or person authorized to sign HIPAA Notice for patient _____

_____

Signature of patient or person Date Patient's relationship to person Authorized to consent

_____

Printed name of patient Patient DOB

_____ _____

Signature of Guarantor Date Patient's Relationship to Guarantor

_____

Signature of Witness Date

HIPPA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices describe how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside your protected health information may be used and disclosed by your physician, our office staff and other outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to physician to whom you may have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining, approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office for learning purposes.

We may use or disclose your protected health information in the following situations without your authorization. These situations include, as required by law: Public Health issues as required by law, Communicable Diseases, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Corners, Funeral Directors, and Organ donation, Research, Criminal Activity, Military Activity and National Security, Worker's Compensation, Inmates.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on this use of disclosure indicated in the authorization.

Your Rights: following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however you may not inspect or copy the following records: psychotherapy notes, information complied in reasonable anticipation of or use in, a civil criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits your request in writing to Culture of Life Family Health Care, Medical Records. You have a right to receive a copy within 30 days of your written request.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to receive an accounting of certain disclosures we have made of any of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was re-published and becomes effective on/or before February 12, 2015.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. Please call our office if you have any questions.

I acknowledge that I have read the HIPPA Notice of Privacy Practices. I am signing in the space provided below and giving this along with my Patient Information Sheet with a copy of my Insurance Card.

_____ _____

Signature Date

RX CONSENT

I, _____, give permission for COLFS Medical Clinic to retrieve my prescription history from an external source.

_____

Name Date

Consentimiento de Prescipciones Medicas

Yo, _____, doy permiso para que COLFS Medical Clinic recuperar mi historial de recetas de una fuentes externas.

_____

Nombre Fecha

Staff Initials: _____

Advanced Directives Acknowledgement

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF ADVANCED DIRECTIVE INFORMATION AND FORMS

I acknowledge that I have been given information regarding my right to create Advanced (healthcare) Directives by the staff of Culture of Life Family Healthcare.

I understand that this information will become a part of my permanent medical record.

*If a copy of the package is required, please see receptionist at the front desk.

Name: _____ Date: _____

RECONOCIMIENTO DE LA DECLARACION DE VOLUNTAD ANTICIPADA

Yo reconozco que el personal de Culture of Life Family Healthcare me ha dado la informacion con respecto a mi derecho a crear mi Declaracion de Voluntad Anticipada.

Entiendo que esta informacion formara parte de mi record medico.

*Si require una copia de dicha forma, favor de ir a recepcion.

Nombre: _____ Fecha: _____

PERMISO PARA PROPORCIONAR INFORMACION MEDICA

_____ Iniciale aqui si usted desea que SOLO se le proporcione informacion medica a usted.

O

Favor de escribir el nombre de las personas con quienes usted nos permite poder proporcionar informacion medica, (por ejemplo; resultados de sangre, radiologia, instrucciones del medico, etc.), en caso de que usted no estuviera disponible. A menos de que usted indique de otra manera, se le dejara mensaje en su buzon telefonico de casa o cellular con instrucciones para llamar a la oficina tan pronto usted pueda.

ESTA AUTORIZACION SERA VIGENTE HASTA QUE SEA REVOCADA POR ESCRITO

Persona(s) Autorizada	Relacion con usted	Numero telefonico
_____	_____	_____
_____	_____	_____
_____	_____	_____

Nombre del Paciente: _____ Fecha de Nacimiento: _____

Firma: _____ Fecha: _____