HEALTH HISTORY QUESTIONNAIRE

Name: _____ DOB: _____

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE REQUIRED AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit:

_____

Other concerns:

_____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1._____	_____
2._____	_____
3._____	_____

FAVORITE PHARMACY: _____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____
7._____	_____	_____
8._____	_____	_____
9._____	_____	_____
10._____	_____	_____

IMMUNIZATION HISTORY

- ☐ Chickenpox Date:_____
- ☐ Flu Shot Date:_____
- ☐ Gardasil/HPV Date:_____
- ☐ Hepatitis A Date:_____
- ☐ Hepatitis B Date:_____
- ☐ MMR (Measles, Mumps, Rubella) Date: _____
- ☐ Pneumonia Date: _____
- ☐ TDAP Date: _____
- ☐ Tetanus Date: _____
- ☐ Shingles Date: _____

FAMILY MEDICAL HISTORY ❑ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

✔ CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer (type:_____)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Alive?	Other:_____	Other:_____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
Maternal Grandmother																		
Maternal Grandfather																		
Paternal Grandmother																		
Paternal Grandfather																		
Other:_____																		

SOCIAL HISTORY

Education ☐ Less than 8th grade
☐ High school
☐ 2 year college ☐ 4 year college
☐ Post graduate

Marital Status ☐ Married ☐ Single
☐ Divorced ☐ Separated ☐ Widowed
☐ Domestic partner

Exercise Level
None (No exercise)
Occasional exercise
Moderate exercise
High level exercise

Caffeine ☐ None ☐ Occasional
☐ Moderate ☐ Heavy
# of cups/cans per day?
____

Alcohol Do you drink alcohol?
☐ Yes ☐ No
If so, how often?
☐ Occasionally ☐ < 3 times a week
☐ > 3 times a week
How many drinks per week? __

Tobacco Do you use tobacco?
☐ Yes ☐ No
If not currently, did you ever use tobacco? ☐ Yes ☐ No
☐ Cigarettes -____pks./day
☐ Chew - ____/day
☐ Cigars - _____/day
☐ # of years____
Or year quit _____

Drugs Do you currently use recreational or street drugs? Yes No
If yes, list:
_____
_____

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ ☐ Abnormal
Last Mammogram Date _____ ☐ Abnormal

Age of first menstrual period: _____
Date of last menstrual period or age of menopause: _____
Number of pregnancies: _____ births: _____
miscarriages: _____ abortions: _____
☐ Cesarean sections If yes, then number: _____

☐ Bleeding between periods
☐ Heavy periods
☐ Extreme menstrual pain
☐ Vaginal itching, burning, or discharge
☐ Wake in the night to go to the bathroom
☐ Hot flashes
☐ Breast lump or nipple discharge

SEXUAL HISTORY (all genders)

Current sexual partner is Female Male

Do you use condoms No Yes

Other Birth control method used:_____

☐ Interested in being screened for STD's

MEN ONLY

Testicular Pain Yes No

Groin Pain Yes No

Last prostate exam Date:_____ _

PAST SURGICAL HISTORY

	SURGERY	REASON	YEAR	HOSPITAL
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

PAST MEDICAL HISTORY

Please check all that apply:

☐ Anxiety Disorder
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Blood Clots (or DVT)
☐ Cancer
☐ Coronary Artery Disease
☐ Claustrophobic
☐ Diabetes - Insulin
☐ Diabetes - Non-Insulin
☐ Dialysis
☐ Diverticulitis
☐ Fibromyalgia
☐ Gout
☐ Has Pacemaker
☐ Heart Attack
☐ Heart Murmur
☐ Hiatal Hernia or Reflux Disease
☐ HIV or AIDS
☐ High Cholesterol
☐ High Blood Pressure
☐ Overactive Thyroid
☐ Kidney Disease
☐ Kidney Stones
☐ Leg/Foot Ulcers
☐ Liver Disease
☐ Osteoporosis
☐ Polio
☐ Pulmonary Embolism
☐ Reflux or Ulcers
☐ Stroke
☐ Tuberculosis
☐ Other

REVIEW OF SYSTEMS

Please circle all that apply:

Constitutional:
Fever
Night sweats
Weight gain
Weight loss
Exercise intolerance
Lethargy
Chills

Eyes:
Dry eyes
Irritation
Vision change
Eye disease/injury

ENT:
Difficulty hearing
Ear pain
Frequent nose bleeds
Nose issues
Sinus issues
Snoring
Sore throat
Dry mouth
Mouth breathing
Ringing in ears
Sinusitis

Allergy:
Runny nose
Sinus pressure Itching
Hives
Frequent sneezing

Cardiovascular:
Chest pain on exertion
Arm pain on exertion
SOB when walking
SOB when laying down
Palpitations
Heart murmur
Light-headed on standing
Ankle swelling

Respiratory:
Cough
SOB
Coughing up blood
Sleep apnea

Gastro:
Nausea
Vomiting
Constipation
Change in appetite
Black or tarry stools
Diarrhea
Vomiting blood
Dyspepsia
GERD

Hematologic/ Lymphatic:
Swollen glands
Easy bruising
Anemia
Excessive bleeding

Genitourinary:
Loss of urinary control
Difficulty urinating
Increased urinating
Hematuria
Incomplete emptying

Musculoskeletal:
Muscle aches
Muscle weakness
Joint Pain
Back pain
Swelling in extremities
Neck pain
Difficulty walking
Cramps
Osteoporosis
Fractures

Neuro:
Loss of Consciousness
Weakness
Numbness
Seizures
Dizziness
Headaches
Migraines
Restless legs
Tremor
Paralysis

Skin:
Abnormal mole
Jaundice
Rash
Itching
Dry skin
Growths/lesions
Laceration
Changes in hair/nails
Psoriasis
Change in skin color
Breast lump

Psych:
Sleep issues
Depression
Anxiety
Icohol abuse
Hallucinations
Suicidal thoughts
Mood swings
Memory loss
Agitation

Endocrine:
Fatigue
Increased thirst
Hair loss

2404 Newburg Rd.
Fortuna, CA 95540

Chart # _____

Fortuna Family Medicine Inc.

PATIENT REGISTRATION (Minor- 17 and under)

PATIENT INFORMATION

First Name:_____ Last Name:_____ Middle Initial:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home Number:_____ Cell Number:_____ Work:_____

Date of Birth:_____ Gender: M F NB Preferred Pronouns:_____

Race:_____ Ethnicity:_____ SSN:_____

Preferred Language: _____ Marital Status:_____ E-mail Address:_____

Preferred Name:_____

EMERGENCY CONTACT:

First Name:_____ Last Name:_____

Home Number:_____ Cell Number:_____ Work:_____

Relationship to patient:_____

RESPONSIBLE PARTY INFORMATION *(if different from patient)*

First Name:_____ Last Name:_____ Middle Initial:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home Number:_____ Cell Number:_____ Work:_____

Date of Birth:_____ Gender: M F NB Marital Status:_____

Relationship to patient:_____

INSURANCE POLICY HOLDER INFORMATION

Per FFM Policy, patients must present insurance card and drivers license to be copied at intake. *Unfortunately, patients without valid insurance card and ID will not be checked in and will need to reschedule their initial appointment.*

ADVANCED DIRECTIVE

Do you have an advanced directive? (Living Will) YES_____ NO_____

If not, would you like to receive one today? YES_____ NO_____

Office use only
*Advanced directive given by:*_____

CALIFORNIA IMMUNIZATION REGISTRY (CAIR)

Keeping track of shots/TB tests you have received can be hard, especially if more than one doctor gave them. For your convenience, FFM participates in the California Immunization Registry (CAIR), a secure computer system to keep track of these for you. If you change doctors, your new doctor can use the registry to see your shot/TB test record. You may opt out if you wish:

☐ I DECLINE TO ALLOW my immunization/tuberculosis (TB) screening test record to be shared with other health care providers, agencies, or schools in the California Immunization Registry (CAIR).

Note: The immunization record/TB tests may still be recorded in the registry for use by FFM By law, public health officials can also access immunization/TB test records in the case of a public health emergency.

Lab Work and Forms

Any lab work that is not performed at FFM is sent out to a reference laboratory. The fees associated with these tests are ***in addition*** to your current charges with FFM and will be billed separately to your insurance carrier as a courtesy by the lab; however, you are ultimately responsible for these charges and may receive a bill directly from the lab, for which you are responsible.

Patients who request healthcare-related or other forms/paperwork/applications filled out or signed will be charged an additional fee.

Medication Refill Policy

It is the policy of FFM that all patients should have their prescription refilled during their normally scheduled office visit. When this is not possible, any other medication refill requests should be made through your pharmacy 3-5 days before your medication will run out. The pharmacy will forward the necessary information to our office.

- Patients are required to give 3 business day's notice for prescriptions that need to be refilled.
- There are strict controls for medications containing opioids. The patient should have their prescription refilled during their normally scheduled office visit.
- FFM does not refill medications prescribed by other physicians, unless our practitioner first evaluates the patient.
- The patient is responsible for knowing when their medication(s) are getting low. If a medication is getting low, the patient should confirm that they have an appointment scheduled with our office before their medication will run out.
- Patients are not to request early refills of controlled medications that are overused, lost, or stolen.

Providers and Consent to Treat

I understand that FFM employs Advanced Practice Providers (Nurse Practitioners and Physician Assistants) and consent to their involvement in my care.

I hereby request my physician, APP and/or other health care providers or their designees, to perform medical examination, testing, treatment, and care as they may deem necessary and available to me during my office visit or outpatient procedure, including but not limited to tests, examinations, anesthetics, x-rays, medical and surgical treatments, and other prescribed procedures.

You have the right to discuss your treatment plan with your physician, including the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions. All patients have the right to accept or refuse medical or surgical treatment.

Telehealth Consent

I consent to the use of Telehealth for the delivery of health care services. Telehealth includes medicine, and involves the use of audio, video, or other electronic communications to interact with me, consult with health care providers, and/or review my medical information for the purpose of diagnosis, therapy, follow-up, and/or education.

Body Fluid Exposure

In the event a healthcare worker is exposed to my blood or body fluid in a manner that may pose a risk for transmission of a blood-borne infection during my office visit, I am give my consent to be tested for HIV, HBV, and HCV at no cost to me, so the healthcare worker can be treated promptly. I authorize release of this information to the exposed healthcare worker and his/her healthcare provider.

Non-Traditional Treatments

FFM is committed to improving the wellness of our patients through a combination of traditional medicine and non-traditional, lifestyle-improvement approaches to treatment and prevention of chronic diseases. A non-traditional approach should be used as a supplement and does not replace the need for conventional medical treatment. If patients choose an exclusively non-traditional approach to treatment, they do so at their own risk, and although FFM will support their decisions, should not be held liable for outcomes.

Acknowledgment of Receipt of Notice of Privacy Practices

By signing this document, you acknowledge receipt of the Notice of Privacy Practices and Bill of Rights and Responsibilities from FFM. The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully.

Informed Consent for Medical Services

I understand that various procedures may occasionally be recommended by my provider. These procedures may be relatively routine such as an injection of a medication or a more detailed procedure such as lesion excision, shave, suturing, steroid injection, toenail removal either partial or complete, etc. I understand that all procedures have some degree of risk associated with them, including the possibility of allergic reaction, vascular, nerve, tendon, or tissue damage, lipodystrophy (dissolving of fat associated with a steroid injection, causing a dimple or concavity in the tissue), infection, scarring, rash, bleeding and under rare and unusual circumstances, disability or death. I understand the possibility of routine complications and side effects of any medication prescribed or administered either by injection or by mouth, given in the clinic or prescribed to be taken at home. I understand that there is no medicine that is entirely free of potential side effects which are usually mild but could potentially be severe, I accept the possibility of complications or even the chance of severe allergic reaction resulting in death. I accept the responsibility to discuss any concerns with my provider and the pharmacist. I will not take or accept any medication or procedure unless all of my concerns & questions have been addressed to my satisfaction. I will remind and make sure that my provider is aware of any allergies that I have, or past unacceptable side effects to medications or procedures and even the possibility of pregnancy.

Guarantee of Payment

If self pay (considered self pay if valid and active insurance is not presented at time of service): I agree to pay for all services rendered in full at time of visit. I understand that no insurance company will be billed for my services today by FFM. Any procedures or lab tests performed will require a separate fee beyond the standard office visit fee.
If insurance (considered insured if valid and active insurance is presented at time of service): **Assignment of Benefits:** I authorize payment of benefits to FFM for all services performed and billed by FFM. I assign to FFM all of my rights, benefits, interests, claims, remedies, causes of action, privileges, protections, and recoveries of any type whatsoever arising out of or related to any insurance source. **Release of Information:** I authorize the release of any medical, demographic, or other information necessary to process claims, for payment, treatment, or healthcare operations. I further understand that FFM may be permitted or required to disclose health information to government agencies or other organizations for including but not limited to information about infectious diseases. **Other:** I acknowledge that I am ultimately responsible for all charges incurred. I agree that I will pay my estimated balance based on the best available information of my current policy and FFM's current contract with my insurance carrier. I understand this is only an estimate and after my visit is processed with my insurance company, I will be billed for any outstanding balance. While FFM makes every effort to verify my correct insurance information prior to leaving, I understand FFM cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier and that I am ultimately responsible for all charges incurred. My signature on these policies is herein on file for all billing claim forms. I authorize all insurance sources to pay FFM directly for all services I receive. If I receive services not covered by an insurance source, then I agree to pay all charges for those services. If my account is referred to an attorney or collection agency, then I agree to pay actual collection costs, including attorney's fees and interest. If there is a credit balance on my account, I authorize FFM to apply the credit balance to all unpaid services on my account (or my guarantor's accounts). I authorize FFM to release my confidential medical information verbally, electronically, and/or in writing, to my insurance carrier, and other health care providers involved in my care, for purposes of treatment, payment of charges, quality assurance, utilization review, transfer, referrals, etc. I further authorize FFM to download my medication history as prescribed by other providers, to become part of my medical record at FFM.

Parent Identification for Minors

Please provide the full legal names of both parents OR legal guardian(s) if patient is under the age of 18.

Name of Parent/Guardian 1:_____
Name of Parent/Guardian 2:_____

Indicate if: ___ Mother or ___ Father does not have legal rights to access the minor's information or cannot accompany the minor to clinic appointments. Legal documentation must be provided to support this claim.

Photos Consent

I consent to the taking of photographs or videos of my medical condition or treatment, and the use of these images for the purposes of my diagnosis or treatment or operations.

Release For Family And Friends

If you wish to authorize FFM to discuss or share your health information with family or friends, you must do so here:
I, THE PATIENT, HEREBY AUTHORIZE FFM TO DISCUSS OR OTHERWISE RELEASE ANY OR ALL OF MY PERSONAL HEALTH INFORMATION OR MEDICAL RECORDS INCLUDING DIAGNOSES, LAB RESULTS, AND OTHER TESTS, ETC., BY PHONE, IN WRITING, OR IN PERSON TO THESE FAMILY MEMBERS OR FRIENDS ONLY:

Name 1: _____
Address: _____
City/State/ZIP:_____
Phone:_____

Name 2: _____
Address: _____
City/State/ZIP:_____
Phone:_____

Name 3: _____
Address: _____
City/State/ZIP:_____
Phone:_____

Permission for "Qualified Adult Relative" to accompany a Minor

If you, as the parent or guardian of the minor, desire a "Qualified Adult Relative" (QAR) to have permission to accompany your child to any of their clinic visits, we need you to complete the following information. To be a QAR, the person must be at least 18 years of age, and could be an adult spouse, parent, step-parent, sibling, step-sibling, half-sibling, uncle, aunt, niece, nephew, first cousin, or any person denoted by the prefix "grand" or "great," or the spouse of any of those persons. This section is applicable if the name field, below, is completed.
I give permission to the following alternate person to accompany my child to FFM. I give permission for this person to seek and approve treatment for my above mentioned child (including medical exam, procedures, medications, immunizations, diagnostic testing, mental health care, etc.) and provide consent for such treatment. I wish to grant permission to a QAR to accompany my minor by completing the field below. My signature on the last page of this packet serves as a signature to this section.

_____
Print the name of QAR

Consent to Treat Minors

This section is for parents or legal guardians of a patient under 18 years of age.

I, the undersigned parent or legal guardian of a minor, do hereby request and authorize that FFM provider and other healthcare providers or their designee, to perform medical examinations, testing, treatment, and other care as may be deemed necessary and available for my child during his/her office visit or outpatient procedure. I understand that by signing this consent, I am authorizing FFM to treat my child for as long as I seek care for my child from this facility, or until I withdraw my consent in wiritng. I understand that one of the parents (with custody), or the legal guardian, or my Alternate Designee (see below) must be present each time my minor child is seen in the clinic, unless the minor is seeking care under the Sensitive Services for Minors laws. I understand I have the right to discuss my child's treatment plan with their provider, including the purpose, potential risks, ands benefits of any test or treatment that is recommended.

I certify that I am the parent (with custody) of the minor in this registration packet, or the legal guardian of the minor patient listed in this packet. I have read and fully understand the above "Consent for Minors" and I fully and volunmtarily consent to its contents, including consent to having my minor child or the minor over whom I have legal guardianship, treated by FFM. My signature in the fields below and on the last page of this packet serves as a signature to this section.

Print Minors Patients Name:_____

Print Name of Parent or Legal Guardian:_____

Signature of Parent of Legal Guardian:_____

Date:_____

Contact Permissions:

FFM may contact me (or leave message) to convey appointment, diagnostic, clinical, or any other healthcare information by:

____ Home phone ____ Cell Phone ____ Work Phone

____ E-mail address ____Mailing address

How Did You Hear About Us?

_____Insurance assigned me _____Social Media

_____Referred by family/friend _____Internet Search

_____Other (please specify):_____

FINAL SIGNATURE

I certify that the information I have provided is complete and accurate to the best of my knowledge. I have also read,, understand, and agree to all sections, and all pages, and all policies contained in this Patient Registration/ Intake packet, and my signature on this page effectively signs, approves, agrees to, and legally binds me to each of these sections, pages, and policies including, but not limited to:

- Lab Work
- Forms
- Body Fluid Exposure
- Medication Refill Policy
- Providers and Consent to Treat
- Telehealth Concent
- Non-Traditional Treatments
- Acknowledgement of Receipt of Notice of Privacy Practices
- Guarantee of Payment
- Liability and Cost Share
- Release of Family and Friends
- Photos Consent
- Informed Consent for Medical Services
- Consent to Treat Minors/ QAR Permission
- Legal Guardian
- Representative or Caregiver
- Contact Permissions

_____

Patient Name *(please print)*

_____

Signature *of Patient or Patient Representative* *MM/DD/YYYY*

_____

Name of Patient Representative *(please print)* *MM/DD/YYYY*

_____

If Patient Representative*: Relationship to Patient* *MM/DD/YYYY*

Fortuna Family Medicine Inc.

Nathan Brinckhaus, M.D.
Fannette Downie-Allman, F.N.P.
Loida Brinckhaus, F.N.P.

Late Policy:

- We schedule appointments according to urgency and availability
- In order to receive the maximum benefit from care, it is important to adhere to this schedule.
- New Patients – Please arrive 20 minutes early to complete the necessary paperwork require
- Established Patients – please arrive 10 minutes early
- **If you are 10+ minutes late, we will need to reschedule your appointment**
- If you find that you are running late, please call our office to determine if we can hold your appointment.
- If for any reason you are unable to keep your scheduled appointment, you must give our office 24-hour notice

No show policy:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

If you schedule changes and you cannot keep your appointment, please contact the office at least 24 hours in advance so we may reschedule you and accommodate those patients who are waiting for an appointment.

If an appointment is not cancelled 24 hours in advance, we will record this in your file.

If you get 3 no shows or same day cancellations, you may be subject to dismissal from our practice.

By signing the below, you have read and agree to the above policies.

X_____

Printed Name

X_____ _____

Signature Date

2404 Newburg Rd.
Fortuna, CA 95540

(707) 617-2002
(833) 941-4882

Fortuna Family Medicine Inc.

Nathan Brinckhaus, M.D.
Fannette Downie-Allman, F.N.P.
Loida Brinckhaus, F.N.P.

PPD Questionnaire (TB)

Patient Name: _____

Date of Birth: _____

Tuberculosis symptoms review (Questions 1-7 MUST be answered by everyone)

Do you currently have any of the following symptoms? (circle yes/no answers)

1.	Unusual fatigue	Yes	No
2.	Weight loss (unrelated to dieting)	Yes	No
3.	Loss of appetite for more than two weeks	Yes	No
4.	Persistent cough longer than two weeks	Yes	No
5.	Blood-streaked sputum	Yes	No
6.	Fever associated with cough for more than two weeks	Yes	No
7.	Night Sweats	Yes	No

- ☐ **Negative History:** means that you do not have documented positive reaction to the PPD skin test in the past.
- ☐ **Positive History:** means that you have had a documented positive reaction to the PPD skin test in the past.

I certify to the best of my knowledge that the above statements are true.

_____ _____

Signature Date

2404 Newburg Rd.
Fortuna, CA 95540

(707) 617-2002
(833) 941-4882

Fortuna Family Medicine Inc.

Nathan Brinckhaus, M.D.
Fannette Downie-Allman, F.N.P.
Loida Brinckhaus, F.N.P.

I authorize information to be released to: **Records From:**

Name of Facility: Fortuna Family Medicine Inc.	Name of Facility:
Address: 2404 Newburg Rd.	Address:
City, State, Zip: Fortuna, CA 95540	City, State, Zip:

Phone:	Fax:

Purpose of release: (circle all that apply)

Medical Care Personal Legal Other:_____

Type of information to be released (records will be limited to the last two years unless otherwise indicated):

- ☐ General Health Records (physician reports, diagnostic reports, hospital reports, lab/pathology reports, consultation reports, immunizations)
- ☐ Workers Comp. Injury Initial:_____
- ☐ PT/OT Reports Initial:_____
- ☐ HIV/Aids Treatment Initial:_____
- ☐ Mental Health Treatment Initial:_____
- ☐ Drug/Alcohol Treatment Initial:_____
- ☐ Genetic Testing Information Initial:_____

Authorization Information:

I understand the following:

1. I authorize the use or disclosure of health information as described above for the purpose listed. I understand this authorization is voluntary.

Fortuna Family Medicine Inc.

Nathan Brinckhaus, M.D.
Fannette Downie-Allman, F.N.P.
Loida Brinckhaus, F.N.P.

2. I have the right to revoke this authorization. To do so I understand I must submit my revocation in writing to the party entered in Part II. The revocation will prevent further release of my health information from the date of receipt.

3. I am signing this authorization voluntarily and understand my health care treatment will not be affected if I do not sign this authorization.

4. The party entered in Part III is prohibited from re-disclosing the health information except with a written authorization or as specifically permitted by Cal. Code §56.10 or required by law (applies within California only).

5. If the party entered in Part III is not a HIPAA Covered Entity or Business Associate as defined in 45 CFR §160.103, the released health information may no longer be protected by federal and state privacy regulations.

6. I have a right to receive a copy of this authorization.

7. Fees may be charged to cover the cost of releasing the health information.

8. I understand that my substance abuse disorder records are protected under the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records and cannot be redisclosed without my written authorization.

Patient Information and Signature:

First Name:_____ Last Name:_____

Date of Birth:_____ Phone Number:_____

Address:_____ City:_____ State:_____ Zip:_____

X_____ _____ _____

Signature of patient of legal representative Relationship to Patient Date

2404 Newburg Rd.
Fortuna, CA 95540

(707) 617-2002
(833) 941-4882

Fortuna Family Medicine Inc.
Patient Satisfaction Survey

Dear Patient,

We want every patient to have a positive experience every time they come to our clinic. We would like to know how you think we are doing. Please take a few minutes to fill out this survey and drop it off at the comment box on your way out. Thank you so much.

Please rank the following statements based on your visit today:

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. The non-clinical staff at this office (including receptionists and clerks) were as helpful as I thought they should be				
2. The non-clinical staff at this office were friendly to me				
3. The non-clinical staff at this office addressed my concerns adequately.				
4. I was given more than one option in terms of how and when to schedule the next appointment.				
5. I felt comfortable asking the non-clinical staff questions.				
6. When I called for an appointment, the wait time was reasonable.				
7. I was given an appointment when I wanted it.				
8. I feel confident that my personal information is kept private.				
9. The medical clinic was clean and sanitary.				
10. The medical team listened to my concerns.				
11. The medical provider communicated clearly.				
12. I would recommend this medical clinic to others.				