Valley Internal
VIP
Physicians

Consent for Patient Contact

I, _____ , hereby give my consent for the physicians and staff at Valley Internal Physicians to contact me regarding appointments and confidential health information via (please check all that apply):

- ❒ Message with spouse / friend / caregiver: _____
- ❒ Mail
- ❒ Answering machine / Voicemail – home / work (please circle)
- ❒ Fax #: _____
- ❒ Cell phone #: _____
- ❒ E-mail address: _____

- ❒ DO NOT CONTACT ANYONE OTHER THAN ME PERSONALLY

_____ _____
Patient Name (please print) D.O.B.

_____ _____
Patient Signature Date

Jason A. Black, M.D.
24680 Jefferson Avenue, Suite A • Murrieta, CA 92562
Tel: (951) 677-2252 • Fax: (888) 379-5709

VALLEY INTERNAL VIP PHYSICIANS

Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your *best possible health* requires a partnership between you and your doctor. We ask you, as our "partner in health," to help us in the following ways:

- ***Schedule visits with my doctor for routine physical exams and other recommended health screenings.***
  I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears, etc.). These health screenings are tests that can help detect life-threatening diseases and conditions. If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.
- ***Keep follow-up appointments and reschedule missed appointments.***
  I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible. I also understand I may be charged a fee for missed appointments or same-day cancellations.
- ***Call the office when I do not hear the results of lab and other tests.***
  I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.
- ***Inform my doctor if I decide not to follow his or her recommended treatment plan.***
  I understand that, after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that NOT following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide NOT to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you at any time to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Patient Signature	Date	Physician Signature

JASON A. BLACK, M.D.
24680 JEFFERSON AVENUE, SUITE A • MURRIETA, CA 92562
TEL: (951) 677-2252 • FAX: (888) 379-5709

VALLEY INTERNAL
VIP
PHYSICIANS

Authorization for Use/Disclosure of Health Information

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

It is the policy of this medical practice that we will adopt, maintain, and comply with our Notice of Privacy Practices, which shall be consistent with HIPAA and California Law.

Authorization: I hereby authorize _____
(Enter name of physician or healthcare facility from whom you are requesting records.)

to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records (including those from my other healthcare providers that the above named healthcare provider may hold), by means of mail, fax, or other electronic methods to:

Valley Internal Physicians
24680 Jefferson Avenue, Suite A
Murrieta, CA 92562
Phone: (951) 677-2252
Fax: (888) 379-5709
Secure e-mail: documents@VIPMurrieta.com

The medical information/records will be used for the following purpose: _____

This authorization is:
- ❒ Limited to the following medical information: _____
- ❒ Unlimited (all records, excluding Substance Abuse, Mental Health, HIV diagnosis/treatment)

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____ (initial) HIV Diagnosis/Treatment _____ (initial)

Psychiatric/Mental Health _____ (initial) Genetic Information _____ (initial)

Tests for Antibodies to HIV _____ (initial)

Duration: This authorization shall be effective immediately and remain in effect for one year from the date shown below.

Restrictions: Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of patient *or legal representative* Relationship *if other than patient*

_____ _____
Patient's Name (PRINT) Date

_____ _____
Patient's Social Security Number Patient's Date of Birth

_____ _____
Witness Name Witness Signature

Valley Internal VIP Physicians

Patient Name: _____ DOB: _____

Please list below any past or current medical conditions:

_____

_____

_____

_____

Please list any surgeries you have had:

Type of surgery	Date / Year	Hospital / Facility

FAMILY HISTORY

Please indicate medical conditions in your immediate family:

❒ Adopted

Mother: _____

Father: _____

Sister: _____

Brother: _____

SOCIAL HISTORY

Occupation: _____

Retired: ❒ Yes ❒ No

Disability: ❒ Yes ❒ No

Marital status: ❒ Married ❒ Separated ❒ Widowed ❒ Unmarried ❒ Divorced

LIFESTYLE

Do you or did you smoke? ❒ Yes ❒ No

How many packs per day? _____ How long? _____

When did you quit? _____

Do you drink alcohol? ❒ Yes ❒ No

How often? _____

Have you ever used or are you currently using illicit drugs? ❒ Yes ❒ No

Please explain _____

_____

Jason A. Black, M.D.
24680 Jefferson Avenue, Suite A • Murrieta, CA 92562
Tel: (951) 677-2252 • Fax: (888) 379-5709

Valley Internal
VIP
Physicians

MEDICAL HISTORY
Please list all medications you are currently taking and why
(Continue on back of this sheet if necessary):

Medication / dosage	Reason for medication

Please list any medication allergies:

Medication name	Reaction

Jason A. Black, M.D.
24680 Jefferson Avenue, Suite A • Murrieta, CA 92562
Tel: (951) 677-2252 • Fax: (888) 379-5709

VALLEY INTERNAL
VIP
PHYSICIANS

REVIEW OF SYSTEMS
Please check Yes or No to the following health questions, past or present:

Cardiovascular (Heart disease, high blood pressure, CHF)	❒ Yes	❒ No
Gastrointestinal (GERD, IBS, diverticulitis, liver disease)	❒ Yes	❒ No
Genitourinary (Kidney stones, incontinence, enlarged prostate)	❒ Yes	❒ No
Hematologic (Anemia, blood clots, easy bruising)	❒ Yes	❒ No
Metabolic (Diabetes, thyroid disease, high cholesterol)	❒ Yes	❒ No
Musculoskeletal (Arthritis, lupus, fibromyalgia, back pain)	❒ Yes	❒ No
Neurologic (Seizures, headaches, tremors, fainting spells, stroke)	❒ Yes	❒ No
Oncologic (Cancer, leukemia, lymphoma)	❒ Yes	❒ No
Psychological (Depression, anxiety, sleep disorders)	❒ Yes	❒ No
Respiratory (Asthma, COPD, chronic cough)	❒ Yes	❒ No
Skin (Psoriasis, rashes, edema)	❒ Yes	❒ No

PREVENTIVE SERVICES
Have you had any of the following:

Physical exam	❒ Yes	❒ No	Date _____
Cholesterol check	❒ Yes	❒ No	Date _____
Colonoscopy	❒ Yes	❒ No	Date _____
Bone density test	❒ Yes	❒ No	Date _____

Immunizations:

Pneumonia vaccine	❒ Yes	❒ No	Date _____
Shingles vaccine	❒ Yes	❒ No	Date _____
Flu shot	❒ Yes	❒ No	Date _____
Tetanus booster	❒ Yes	❒ No	Date _____

FEMALES ONLY:
When was your last mammogram? _____
When was your last Pap smear? _____

Have you gone through menopause?	❒ Yes	❒ No
Have you taken hormone replacement?	❒ Yes	❒ No

DIABETICS:
What was your last hemoglobin A1c level? _____ Date _____

Signature _____ Date _____

JASON A. BLACK, M.D.
24680 JEFFERSON AVENUE, SUITE A • MURRIETA, CA 92562
TEL: (951) 677-2252 • FAX: (888) 379-5709

Valley Internal
VIP
Physicians

"Between You And Your Doctor"

Name: _____ Date: _____

What is the main reason for your visit today? _____

_____

_____

What other things would you like to review if possible? Please list in order of importance:

1. _____
2. _____
3. _____
4. _____

Do you need any of the following:

- ❒ Prescription renewal(s): _____

  _____
- ❒ Forms filled out
- ❒ Work excuse
- ❒ Other: _____

  _____

Jason A. Black, M.D.
24680 Jefferson Avenue, Suite A • Murrieta, CA 92562
Tel: (951) 677-2252 • Fax: (888) 379-5709