Dr. Rachel Mayorga MD

New Patient Information

Name:_____

Date of Birth:_____

Today's Date:_____

Please bring to your appointment all of your medication bottles and supplement bottles so we can accurately enter them in our system.

FYI if you are on chronic narcotic pain medication, I do require you to be followed by a pain specialist.

Please bring a copy of your living will, advanced directive or POLST if you have them.

Any allergies to medications?_____

Health History: Please list any current or past major health conditions

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_____

_____

_____

_____

_____

_____

Surgical History: Please list surgeries and dates of surgeries

_____

_____

_____

_____

Family History: Any family members with:

Diabetes: Yes No

Heart disease: Yes No

Cancer: Yes No What type?_____

Please give individual medical illnesses, ages or age at death.

Father:_____

Mother:_____

Siblings:_____

_____

_____

Children:_____

_____

_____

Who do you live with? _____

Pets? _____

What type of work do/did you do? _____

How much education do you have? _____

Please list Hobbies, interests: _____

_____

_____

_____

Habits:

Smoking: Cigarettes or other?_____

How many years did you smoke?_____

What year did you quit?_____

How many packs per day?_____

Do you use cannabis?_____

Do you use illegal drugs?_____

Sexual Activity:

Are you sexually active? _____

Are you in a monogamous relationship? _____

Diet and Exercise:

Describe your diet: _____

Describe your exercise routine:

_____

Safety:

Do you feel safe? Yes No

Do you feel threatened by anyone? Yes No

Do you have smoke and carbon monoxide detectors in your home? Yes No

Do you have guns in your home? Yes No

If yes, are they locked & ammo stored separately? Yes No

Medical Forms: Do you have: circle yes or no

Advances Directive for Health Care?	Yes	No
Durable Power of Attorney for Healthcare decisions?	Yes	No
Living Will?	Yes	No
POLST?	Yes	No

Rachel Mayorga, MD

PERSONALIZED MEDICAL CARE

Patient Contact Information

Date: _____

Name: _____

DOB: _____

Best number to contact you: _____

Address: _____

Local Pharmacy: _____

Mail Order Pharmacy: _____

May Dr. Mayorga or her medical staff leave a message on your phone? Yes or no

Emergency Contact: _____

Phone Number: _____

Is there a family member or friend to whom you would like Dr. Mayorga to give medical information to? Yes or No

If yes, same as emergency contact □

Name: _____

Phone Number: _____

_____

Patient/Guardian Signature Date

Office: 707.385.0222 Fax: 707.629.4849
421 March Ave. Suite D, Healdsburg, CA 95448

Review of Symptoms

Please take a few moments to complete this form before your visit with the doctor.

The following is a list of various symptoms and health habits.
Please check YES or NO to indicate whether any apply to you.
Feel free to add any notes or clarification.

Yes	No	General
☐	☐	energy problems
☐	☐	unexpected weight changes
☐	☐	appetite problems
☐	☐	sleep problems
☐	☐	night sweats
☐	☐	unexplained fevers
☐	☐	swollen glands
☐	☐	easy bruising or bleeding

		Head & Neck
☐	☐	frequent or severe headache
☐	☐	vision problems
☐	☐	hay fever or allergies
☐	☐	tooth or mouth problems
☐	☐	voice changes
☐	☐	stopping breathing while asleep

		Heart & Circulation
☐	☐	racing or pounding heart
☐	☐	chest pain or pressure
☐	☐	unusually tired with activity
☐	☐	trouble breathing when lying down
☐	☐	leg cramps
☐	☐	swollen ankles

		Lungs
☐	☐	shortness of breath
☐	☐	wheezing
☐	☐	persistent cough

Yes	No	Digestive System
☐	☐	heartburn or indigestion
☐	☐	stomach pain
☐	☐	frequent nausea or vomiting
☐	☐	frequent constipation
☐	☐	frequent diarrhea
☐	☐	bowel control problems
☐	☐	black or bloody stools
☐	☐	rectal bleeding

		Kidney & Bladder
☐	☐	painful urination
☐	☐	bladder control problems

		Bones & Muscles
☐	☐	painful muscles
☐	☐	swollen, stiff, painful joints
☐	☐	back or neck problems

		Skin
☐	☐	rash
☐	☐	new lumps or growths
☐	☐	new or changing moles or freckles

		Nervous System
☐	☐	dizziness or fainting
☐	☐	numbness or tingling
☐	☐	unusual weakness
☐	☐	disoriented or confusion
☐	☐	loneliness, sadness or depression
☐	☐	work or relationship problems
☐	☐	any recent falls

Yes	No	Habits
☐	☐	2 or more caffeinated drinks daily
☐	☐	2 or more alcoholic drinks daily
☐	☐	cigarettes
☐	☐	any recreational drugs

Yes	No	Women Only
☐	☐	vaginal rash or discharge
☐	☐	vaginal dryness / discomfort
☐	☐	menstrual problems
☐	☐	bleeding after menopause
☐	☐	pelvic pain or bloating
☐	☐	breast lumps, pain, or changes
☐	☐	hot flashes
☐	☐	sexual difficulties

		Men Only
☐	☐	genital rash or discharge
☐	☐	genital pain or swelling
☐	☐	urine flow problems
☐	☐	waking at night to urinate
☐	☐	sexual difficulties

Any Other Problems or Issues:

Name: _____ Date: _____

Rachel Mayorga MD·421 March Avenue # D· Healdsburg, CA 95448

Dr. Rachel Mayorga MD PC

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

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.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if 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 say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures 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 will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy 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.
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.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint 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 **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • 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 • Share information in a disaster relief situation • Include your information in a hospital directory *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.

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.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

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.**

Help with public health and safety issues	• 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.

Dr. Rachel Mayorga MD PC does not create or manage a hospital directory.

You may view your medical record online through the portal.

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.

2/8/2015

This Notice of Privacy Practices applies to the following organizations.

Dr. Rachel Mayorga MD PC only

Dr. Rachel Mayorga 707-385-0222 rachelmayorgaMD@gmail.com

Rachel Mayorga, MD

PERSONALIZED MEDICAL CARE

I, _____, have received and read
Dr.Rachel Mayorga's privacy policy.

_____

Initial

Open Payments Database Notice

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at openpaymentsdata.cms.gov.

_____

Initial

Disclosure:

I hereby authorize and request my insurance company to pay directly to the provider, the amount(s) due on a claim for services rendered to me or my dependents. I further agree should the amount be insufficient to cover medical expenses, I will be responsible for payment of the difference(s), according to the explanation of benefits. If the nature of the office visit is not covered by the policy, I will be financially responsible to pay the provider the amount of the entire bill. If payment of my account is over 60 days late, or it goes to collection, all fees including collection, attorney fees and applicable finance charges will be my responsibility. I hereby authorize the release of any information necessary for payment of the charges incurred.

_____

Patient/Guardian Signature: Date:

Dr. Rachel Mayorga MD PC · 421 March Avenue Suite D · Healdsburg, CA 95448 Phone: 707-385-0222
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