CCACC Health Consent Form

美京•泛亞醫療中心 服務同意書

PATIENT'S RIGHTS

CCACC Health Center respects the unique differences of our patients and will ensure that health care ethics are maintained for all patients. The following rights will be exercised on our patients' behalf:

1. The patient has the right to considerate and respectful care.
2. The patient has the right to, and is encouraged to, obtain from the doctor/therapist relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.
3. The patient has the right to know the identity of the doctor/therapist, staff, and all involved in patient care.
4. The patient has the right to make decisions about the plan of care prior to and during the course of treatment, and to refuse a recommended treatment or plan of care to the extent permitted by law, and to be informed of the consequences of this action.
5. The patient has the right to every consideration of privacy.
6. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential, except in cases where reporting is permitted or required by law.
7. The patient has the right to expect reasonable continuity of care when appropriate, and to be informed by the doctor/therapist of available and realistic patient care options.

CONSENT TO TREATMENT OF A MINOR CHILD (UNDER THE AGE OF 18)

I authorize physical/occupational/speech therapy/mental health counseling as deemed necessary for my (relationship) _____.

CONSENT TO PHYSICAL/OCCUPATIONAL/SPEECH THERAPY/MENTAL HEALTH COUNSELING

I hereby request and consent to comprehensive evaluation/examinations (PT/OT/SLP/mental health counseling), intervention (including but not limited to soft tissue mobilization, therapeutic exercises, stretching, posture and ergonomic training, home exercise program, activities of daily living training, counseling) from clinicians who now or in the future treat me in this office or via telehealth.

I have had an opportunity to discuss with CCACC Health Center staff the nature and purpose of the treatment indicated. I understand that results are not guaranteed and am informed that, as in the practice of medicine and in the practice of physical/occupational/speech therapies and counseling, there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, sprains, burns, or falls while in the office.

I do not expect the doctor(s) or therapist(s) to be able to anticipate and explain all risks and complications and wish to rely on the doctor(s)/therapist(s) to exercise judgment during the course of any procedure which the doctor(s)/therapist(s) deem at the time to be in my best interest.

I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content, and by signing below, I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment at CCACC Health Center and/or the employed staff.

PAYMENT, INSURANCE, MEDICAL RECORDS, AND USE OF NAME, DISCLOSURE

I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

In light of the COVID-19 Pandemic, CCACC Health Center will observe all precautions and guidance from regulatory bodies and maintain open communication.

I understand CCACC Health Center uses the billing services of Physicians Medical Billing (PMB) in White Marsh, Maryland, and that PMB may also verify my insurance coverage.

I understand I am responsible for any applicable deductibles, co-pays, co-insurances, etc. (Patient Responsibility). I understand my Patient Responsibility will be due at the time of service. I understand CCACC Health Center will make every effort to work with me on a payment schedule, if needed.

I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum owed to this office by my attorney, out of proceeds of any settlement of my case, and by any insurance company contractually obligated to make payment to me or this office based upon charges submitted for products and services rendered.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt.

However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, fees for products or professional services previously rendered will be immediately due and payable.

CCACC Health Center is an independent health care facility that was created for the sole purpose of providing physical medicine and rehabilitative health care services (PT/OT/SLP/counseling/pain management, etc.). CCACC Health Center is not directly affiliated with any hospital or hospital system.

NO SHOW / CANCELLATION / RESCHEDULE / LATE POLICY

CCACC Health Center has the right to charge a fee of $25.00 for appointments not rescheduled within 24 hours of the scheduled time or for not showing up for a scheduled appointment. Payment will be due on the next visit.

If patients show up for appointments more than 30 minutes late, we may need to reschedule the visit, or full treatment will not be given.

By my signature below, I acknowledge that I have read, understood, and agree to the above provisions, and assign my insurance benefits as described above.

_____ _____

(Patient Signature) (Date)

_____

(Patient Name, printed legibly)

PATIENT CERTIFICATION AND CONSENT FORM
病人保證及同意書

I certify that all of the information provided to CCACC Health Center is true and accurate to the best of my knowledge. I hereby voluntarily consent to medical treatment by the medical staff and providers of CCACC Health Center. I further consent to the use and disclosure of my protected health information for treatment, payment, operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act (HIPAA) without a written authorization. A copy of this agreement may be used in place of the original. This authorization is valid until I rescind it in writing.

我保證所有提供給美京•泛亞醫療中心的資料，就我所知都是正確的。我謹此同意接受美京•泛亞醫療中心醫師及醫療人員的診治。我也同意美京•泛亞醫療中心可以在聯邦醫療保險轉移及責任法案 (Health Insurance Portability and Accountability Act) 規定的範圍內，為了治療、付款、手術及其他目的，轉移我的個人醫療資料，不需要再簽署一份同意書。這份同意書的影印本與原件同樣有效。這項授權在我以書面申請作廢之前，一直有效。

_____ _____

Signature of Patient or Parent/ Legal Guardian
病人或法定監護人簽名

Date
日期

_____

Print Name 正楷

FINANCIAL POLICY

1. As a courtesy to our patients, we submit claims to most insurance companies. Although we participate with several managed care plans, the balance that your insurance company does not cover is ultimately your responsibility. In order to ensure your claim is processed promptly, it is necessary that we have all pertinent information at the time services are rendered. This information includes a current copy of your insurance card(s) and a valid referral (HMO/POS/MCares Program).
2. All applicable copays are due at the time of service.
3. New patients without valid health coverage are expected to pay out-of-pocket at the time of service. This does not apply to patients who have MD Medical Assistance, Medicare, or any HMO, POS, PPO, or MCares Program with currently participating providers.
4. If your policy (HMO/POS) requires a referral for specialty services, we will make every effort to alert you when a new referral is necessary. IT IS ULTIMATELY YOUR RESPONSIBILITY TO PRESENT A VALID REFERRAL FOR EVERY VISIT, BEFORE YOU ARE SEEN. Please note the number of visits allowed by your PCP and the length of time for which your referral will be valid. We will not treat any patient without a valid referral at the time of service.

Remark:
As we extend our efforts to set your appointment at a time most convenient for you, we do require a 24-hour cancellation notice. There is a $25.00 charge per missed appointment if notice is not provided within this timeframe.

We reserve the right to dismiss any patient from our practice who exceeds a reasonable number of missed appointments in any calendar year.

I HAVE READ AND AGREE TO THE ABOVE POLICIES:

_____ _____

Name (Print/Typed) Date

_____ _____

Signature Witness Signature

FREE CLINIC FEDERAL TORT CLAIMS ACT (FTCA) PROGRAM
Patient Notice of Limited Liability of
FTCA-Deemed Volunteer Free Clinic Health Care Professionals
Notice to Patients

To be provided to the individual patient before health care services are rendered, except in emergency cases, when notice may be provided as soon as following the emergency as is practicable, or to a parent or legal guardian when the patient lacks legal responsibility for his/her care under state law.

This is to notify you that under federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA) (see 28 U.S.C. §§ 1346(b), 2401(b), 2671–80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by any free clinic volunteer health care practitioner whom the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (see 42 U.S.C. § 233(a), (o)).

Certain free clinic health care professionals providing health care services to patients at this free clinic may be covered by this federal law.

Acknowledged

_____

(Patient Signature)

_____

(Patient Name, printed legibly)

_____

(Date)

CCACC Health Center

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding
CCACC Health Center's Notice of Privacy Practices.

The confidentiality of your protected health information is important to us. This is a summary of the CCACC Health Center Notice of Privacy Practices, which contains a more detailed description of how our clinic will protect your health information, your rights as a patient, and our practices in dealing with patient health information.

Uses and Disclosures of Health Information We will use and disclose your health information in order to treat you or to assist other health care providers in treating you, and in order to obtain payment for our services. We may also disclose your health information for certain limited operational activities, such as quality assessment, licensing, accreditation, and training.

Uses and Disclosures Not Requiring Your Authorization In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care, unless you object;
- For certain limited research purposes;
- For purposes of public health and safety, or to avert a threat to health and safety;
- To government agencies for purposes of their audits, investigations, and other oversight activities;
- To government authorities to report or prevent abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas, or as otherwise required by law;
- For organ or tissue donations, or to the coroner or medical examiner;
- For workers' compensation;
- To business associates who may help us with clinic services.

Uses and Disclosures Based on Your Authorization Except for the circumstances stated above and as allowed under the federal Health Insurance Portability and Accountability Act (HIPAA), we will not use or disclose your health information without your written authorization.

Patient Rights As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions on how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices;
- To complain to the clinic or government agencies;
- To revoke any authorization in writing;
- To obtain more information about our privacy practices.

If you have a question, concern, or complaint regarding our privacy practices, please contact the Privacy Officer (Clinic Director) at 240-393-5950.

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the Practice's Privacy Notice.

_____ _____

Name of Individual (Printed) Date of Birth

_____ _____

Signature of Individual or Personal Representative Relationship if other than patient

PATIENT GRIEVANCE POLICY

POLICY NO: 506

POLICY:

This policy ensures that all patients who visit the Clinic are treated with respect, consideration, and dignity.

PROCEDURE:

All patients are assured confidential treatment and non-disclosure of records, and are afforded the opportunity to approve or refuse the release of such information, except as otherwise permitted by law, third-party payment contracts, or when release is required by law. Each patient will be informed of the name and role of any person providing health care services. The Clinic's Patient Bill of Rights will be posted in the waiting area in a location visible to all patients. If at any time during the visit the patient is dissatisfied with the treatment provided, including unprofessional behavior by staff, the patient has the right—and is encouraged—to file a grievance. Grievances must be submitted to the Medical Director or Clinic Director. All complaints should be submitted in writing, and a written response will be provided within two weeks. The Medical Director and/or Clinic Director will take the following actions:

- Conduct a thorough investigation of all complaints and maintain an office file.
- Maintain the anonymity of patients, staff, and volunteers when required.
- Seek medical, legal, or other professional advice as warranted.
- Administer recommended disciplinary action.

Staff and volunteers may also submit letters of complaint regarding patients and forward written comments and witness statements to the Medical Director and/or Clinic Director.

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION
For eClinicalWorks

I, _____ [PATIENT NAME], a patient at CCACC Health Center ("My Clinic"), understand that eClinicalWorks is a computer-based health information exchange comprised of member healthcare providers like My Clinic (members of eClinicalWorks are called "eCW Members") whose purpose is to provide improved health care to individuals like me by allowing providers who treat me to have access to my medical records. I understand that, unless I notify My Clinic that my medical information may no longer be shared with eClinicalWorks, my medical information (as defined below) will be provided to eClinicalWorks and will be available to eCW Members for purposes of providing me with health care services as further described below, and as otherwise may be permitted by law. However, I understand that even if I notify My Clinic and request that my medical information no longer be shared, my medical information will continue to be available to eCW Members through eClinicalWorks in certain limited situations as permitted by law (for example, in order to avert a serious threat to the health and safety of myself or others).

- *Purpose of use or disclosure of my medical information.* I am authorizing the sharing of my medical information with eClinicalWorks, which allows eCW Members to more easily share my medical information, as defined below, for the purpose of providing me with health care services.
- *Information that is covered by this Authorization.* This Authorization covers information about me that is created or received by My Clinic, as well as other eCW Members, in the course of providing health care services to me, including but not limited to medical, personal, and family household information (together called "my medical information"). This Authorization also covers medical information that eCW Members receive from other providers.
- *Who may receive, use, or disclose my medical information.* I am authorizing only eClinicalWorks to receive, use, and disclose my medical information among eCW Members, including their staff. This Authorization does not allow the disclosure of my medical information to individuals or entities other than eClinicalWorks and eCW Members, except as otherwise permitted or required under federal or state law.
- *Term of Authorization.* This Authorization will remain in effect, unless revoked by me, for a period of ten (10) years from the date I sign this Authorization or any shorter period that may be required by law.

I understand that I may at any time make a written request to My Clinic, or any other eCW Member, to inspect or obtain a copy of my medical information and that the eCW Member will either contact me for a convenient time to inspect or copy my medical information or provide me with a copy or summary of my medical information. I further understand that I may obtain from My Clinic or any other eCW Member a complete list of eCW Members. I understand that a copy of this Authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records.

I understand that the medical information disclosed under this Authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected by law to the same extent as such medical information was protected by law while solely in the possession of the eCW Member.

I understand that I may refuse to sign this Authorization at any time for any reason and that my refusal to sign this Authorization will not affect the commencement, continuation, or quality of treatment I receive by My Clinic or any other eCW Members, unless otherwise permitted by law.

I understand that eCW Members will not sell or receive compensation for the use or disclosure of medical information that is identifiable to me.

I understand that I may revoke this Authorization at any time and that such revocation will not affect the commencement, continuation, or quality of treatment I receive by eCW Members. In order to revoke this Authorization, I understand that I should submit to My Clinic or any other eCW Member a written request to revoke this Authorization. The revocation will be effective upon receipt by an eCW Member of my written request to revoke, except to the extent that action already has been taken in reliance on this Authorization.

I have read and understood the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my medical information. Accordingly, I knowingly and voluntarily authorize any eCW Member to use or disclose my medical information in the manner described above. I understand and agree that this Authorization applies only to the extent that an Authorization is required by law in order for eCW Members to use or disclose my medical information in the manner described above.

I understand that I can notify My Clinic or any other eCW Member at any time of my wish to revoke this Authorization and no longer share my health information electronically.

_____ _____

Signature of Patient Date

If the patient is a minor or otherwise unable to sign this Authorization, please complete the following and provide a copy of documentation that authorizes you to act as the personal representative:

_____ _____ _____

Signature of Personal Representative Relationship Date

_____ _____

Printed Name of Personal Representative Staff Signature/ Title

Strategy for urgent and emergency situations

CCACC URGENT SITUATIONS STRATEGY

Since CCACC Health Center mainly takes care of chronic medical conditions, whenever patients have urgent or emergency situations, please be advised of the following strategies:

1. In the case the patient needs to be seen before the next scheduled appointment, our manager will arrange the patient to be seen at the earliest available appointment.
2. If the patient's condition is relatively urgent, he/she should see the local practitioner or urgent care at his/her own cost. A list of doctors can be found from the local yellow page, newspapers, or online.
3. If the patient's condition is a life threatening emergency, he/she should call 911 or go to the local emergency room at his/her own cost.

病情有特殊與緊急狀況之處理

由於 CCACC 健康醫療中心主要治療非急性之疾病，若其間病人有特殊或緊急之狀況，請按以下建議處理:

1. 若病情需要在下一次預約之前覆診，門診經理會安排病患提前回診。
2. 若病情相對緊急，可到其他私人診所或 urgent care clinic 看病（可從黃頁或報紙查閱），費用自行處理。
3. 若病情危急或有生命危險，請打911或到附近之急診室就醫，費用自行處理。

_____

Signature of Patient or Relative 病患或家屬簽名

Patient Health Questionnaire & General Anxiety Disorder
(PHQ-9 and GAD-7)

Date: _____ Patient Name: _____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

PHQ-9	Not at all (0)	Several days (1)	Most days (2)	Nearly every day (3)
Little interest or pleasure in doing things	▢	▢	▢	▢
Feeling down, depressed, or hopeless	▢	▢	▢	▢
Trouble falling or staying asleep, or sleeping too much	▢	▢	▢	▢
Feeling tired or having little energy	▢	▢	▢	▢
Poor appetite or overeating	▢	▢	▢	▢
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	▢	▢	▢	▢
Trouble concentrating on things, such as reading the newspaper or watching television	▢	▢	▢	▢
Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	▢	▢	▢	▢
Thoughts that you would be better off dead or of hurting yourself in some way	▢	▢	▢	▢

Total Score (add score): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

▢ Not difficult at all ▢ Somewhat difficult ▢ Very difficult ▢ Extremely difficult

GAD-7	Not at all (0)	Several days (1)	Most days (2)	Nearly every day (3)
Feeling nervous, anxious, or on edge	▢	▢	▢	▢
Not being able to stop or control worrying	▢	▢	▢	▢
Worrying too much about different things	▢	▢	▢	▢
Trouble relaxing	▢	▢	▢	▢
Being so restless that it is hard to sit still	▢	▢	▢	▢
Becoming easily annoyed or irritable	▢	▢	▢	▢
Feeling afraid, as if something awful might happen	▢	▢	▢	▢

Total Score (add score): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

▢ Not difficult at all ▢ Somewhat difficult ▢ Very difficult ▢ Extremely difficult

Chronic Pain Questionnaire

▢ Pre ▢ Post

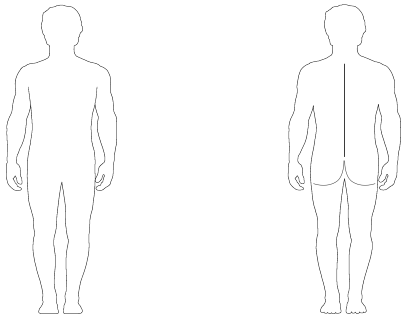
NPI Service: ▢ OT ▢ PT ▢ Acupuncture

Date: _____ Patient Name: _____ Date of Birth: _____

1. During the last week, have you had pain other than everyday kinds of pain (such as sprains, toothaches)?
Yes No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.

R FRONT L L BACK R



3. Rate your pain on average (past week): Circle one number that best describes your **average** pain level.

0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Pain as bad as you can imagine)

4. Rate your pain right now: Circle one number that best describes your **current** pain level.

0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Pain as bad as you can imagine)

5. Circle one number for each item below to show how pain has interfered with your life.

Area of Life	Does Not Interfere									Completely Interferes
A. General Activity	0	1	2	3	4	5	6	7	8	9	10
B. Mood	0	1	2	3	4	5	6	7	8	9	10
C. Walking Ability	0	1	2	3	4	5	6	7	8	9	10
D. Normal Work	0	1	2	3	4	5	6	7	8	9	10
E. Relations with Others	0	1	2	3	4	5	6	7	8	9	10
F. Sleep	0	1	2	3	4	5	6	7	8	9	10
G. Enjoyment of Life	0	1	2	3	4	5	6	7	8	9	10

6. How confident are you that you can manage your chronic pain?

0 1 2 3 4 5 6 7 8 9 10
(Not at all confident) (Totally confident)

7. Do you have a better understanding of your conditions? Yes No

8. Overall, I was satisfied with the services I received. Yes No