***PAGE 1***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Rehoboth Life Care Ministries, Inc.**  **Health Questionnaire/ Cuestionario Sobre Su Salud** | | | | | |
| **Patient Name/ Nombre: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **Date/ Fecha: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **CHECK EACK ITEM/ REVISE CADA PUNTO** | **Yes/Si** | **No** | **CHECK EACH ITEM/REVISE CADA PUNTO** | **Yes/Si** | **No** |
| AIDS/ SIDA |  |  | Hemophilia/Hemofilia |  |  |
| Alcoholism/ Alcoholismo |  |  | Hepatitis A (Infectious) |  |  |
| Allergies (Medicines) /Alergias(Medicinas) |  |  | Hepatitis B |  |  |
| Allergies ( Dust/Pollen) Alergias a polvo/ polen |  |  | Hepatitis C |  |  |
| Alzheimer's Disease |  |  | Herpes/Herpes |  |  |
| Anemia/ Anemia |  |  | High Blood Pressure/ Alta Presión Arterial |  |  |
| Angina (Chest Pain)/ Dolor de Pecho |  |  | High Cholesterol/colesterol alto |  |  |
| Anxiety/Depression |  |  | Hives (rash)/ Urticaria |  |  |
| Arthritis/ Artritis |  |  | HIV Positive/ VIH Positive |  |  |
| Artificial Heart Valve/ Válvula Artificial de Corazón |  |  | Hypoglycemia/Azúcar baja |  |  |
| Artificial Joint/ Coyunturas Artificial |  |  | Jaundice/ Ictericia |  |  |
| Asthma/Asma |  |  | Joint pain/ Dolor de coyuntura |  |  |
| Blood Disease/ Enfermedad de Sangre |  |  | Kidney Problems/ Problema de los Riñones |  |  |
| Breathing Problems/ Enfermedad Respiratoria |  |  | Leukemia/Leucemia |  |  |
| Bruise Easily/Moretón o Sangrado Fácil |  |  | Liver Disease/ Problema de Hígado |  |  |
| Cancer/ Cancer |  |  | Low Blood Pressure/ Baja Presión Arterial |  |  |
| Chemotherapy/ quimioterapia |  |  | Lung Disease/Problema de los Pulmones |  |  |
| Chest Pain/ Dolor de Pecho |  |  | Mitral Valve Prolapse/Prolapso de Válvula Mitral |  |  |
| Cold Sores/Fuegos (Herpes) |  |  | Nausea & vomiting/ Nausea y vómitos |  |  |
| Congenital Heart Disease/Lesion Congenial Corazon |  |  | Nervousness/ Nerviosismo |  |  |
| COPD / Enfermedad obstructiva de pulmones |  |  | Osteoporosis/Osteoporosis |  |  |
| Diabetes/Diabetes |  |  | Pain in Jaw Joints/ Dolor en las Coyunturas |  |  |
| Dizziness/ Mareos |  |  | Psychiatric Care/ Cuidado psiquiátrico |  |  |
| Vertigo/ vértigo |  |  | Recent Weight Loss/ Cambio de peso |  |  |
| Drug Addiction/ Adicción a las droga |  |  | Reflux/ GERD / Reflujo |  |  |
| Ear, nose and Throat Problems/ Problemas de los oídos, nariz, o garganta |  |  | Renal Dialysis/ diálisis de los riñones |  |  |
| Emphysema/Enfisema |  |  | Rheumatic Fever\*/Fiebre Reumática |  |  |
| Epilepsy/Ataques Epiléptico |  |  | Rheumatism/ Reumatismo |  |  |
| Excessive Bleeding/Sangramiento en exceso |  |  | Seizures/ Epilepsia |  |  |
| Fainting/Desmayos |  |  | Scarlet Fever/ Fiebre escarlatina |  |  |
| Fever Blisters/ Ampollas |  |  | Shortness of Breath/ Falta de respiración |  |  |
| Frequent Cough/ Tos Persistente |  |  | Sickle Cell Disease/Células Falciformes |  |  |
| Frequent Diarrhea/Diarrea Frecuente |  |  | Sinus Trouble/ Problemas de Sinusitis |  |  |
| Glaucoma/Glaucoma |  |  | Skin Disease/ Problema de la piel |  |  |
| Hay Fever/Fiebre de Heno |  |  | Stomach/Intestinal Pain/ Dolores de estómago |  |  |
| Headaches/ Dolor de Cabeza |  |  | Stroke/Derrame Cerebral |  |  |
| Heart Surgery/ Cirugía de Corazon |  |  | Swallowing difficulty/ Dificultad tragando |  |  |
| Heart Attack/ Ataque de Corazon |  |  | Swelling of Limbs/ Hinchazón de los pies |  |  |
| Heart Failure/Fracaso de Corazon |  |  | Thyroid Disease/ Enfermedad de Tiroides |  |  |
| Heart Murmur/Sople de Corazón |  |  | Tobacco Use/ Uso de Tabaco |  |  |
| Heart Pacemaker/ Marco Paso de Corazón |  |  | Tuberculosis/Tuberculosis |  |  |
| Heart Disease/ Enfermedad de Corazón |  |  | Ulcers/ Ulceras |  |  |

***PAGE 2***

**Rehoboth Life Care Ministries, Inc.**

**3208 U.S. Highway 41N. Byron, GA 31008**

**Patient Name/ Nombre: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/ Fecha: \_\_\_\_\_\_\_\_\_\_\_**

Reh



** *PAGE 3***

**Rehoboth Life Care Ministries, Inc.**

**3208 U.S. Highway 41N. Byron, GA 31008**

**Phone: 478-953-7770 \* Fax: 478-953-7771 \***

**www.careforlifeclinic.com**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name/ *Nombre*: Date of Birth/*Fecha de Nacimiento***

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**Name & Location of pharmacy/ Nombre de su farmacia**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy Phone #/ Teléfono# de su farmacia**

**List of Allergies/ Alergias:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please bring an updated list of medications that you take at every visit.**

Name of Medication Dosage How long have you been Reason for taking this medication?

*Nombre de su medicina Cantidad Cuantas veces diaria Razon por tomar esta medicina?*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**IF YOU HAVE EVER TAKEN A BISPHOSPHONATE MEDICATION PLEASE TELL YOUR DENTIST PRIOR TO DENTAL TREATMENT.**  
 ***PAGE 4***  
**English**



**Rehoboth Life Care Ministries**

**Receipt of Notice of Privacy Practice**

**Written Acknowledgement Form**

I have had the opportunity to review a copy of Rehoboth Life Care Ministries, Inc.

**Notice of Privacy Practice.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name Relationship to Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

 **Español**

**Recibo de Notificación de la Practica de Privacidad**

**Reconocimiento por Escrito**

Yo he tenido la oportunidad de repasar una copia de la **Notificación de la Practica de**

**Privacidad de la clínica Rehoboth.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nombre del Paciente Parentesco con el Paciente

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Firma Fecha

**Demographic Information - English**

**REHOBOTH LIFE CARE MINISTRIES *PAGE 5***

**Demographic Information - English**

|  |
| --- |
| **Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name: \_\_\_\_\_\_\_\_\_\_\_\_**  **Date of Birth : (\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_) Social Security: \_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_ Sex: Male  Female**  **Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_**  **County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Number where we can leave you a message? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Marital Status: M \_\_ S \_\_ D \_\_ W\_\_**  **Race: White \_\_ Black \_\_ Hispanic \_\_ American Indian \_\_ Asian \_\_ Indian \_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Migrant Worker : Not a farm worker\_\_\_ Temporary worker \_\_\_ Not Homeless \_\_\_ Homeless \_\_\_\_ Public Housing \_\_\_**  **Live with another family \_\_\_ Live in a shelter \_\_\_ Live on the street/car \_\_\_ Live in a transitional home \_\_\_ Live by myself \_\_\_**  **Primary language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Language Barrier? Yes\_\_ No\_\_ Help needed with communication: Yes\_\_ No\_\_**  **Employer’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Retired: Yes \_\_\_\_ No \_\_\_\_ Veteran? Yes\_\_ No \_\_**  **Full time student : Yes\_\_ No\_\_ Part-time Student: Yes\_\_ No\_\_(Name of School) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Información Demográfica - Español** |

**Apellido: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primer Nombre: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Segundo Nombre: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Fecha de Nacimiento (MM/DD/AAAA): (\_\_\_\_\_/\_\_\_\_/\_\_\_\_) Número de Seguro Social \_\_\_\_\_\_- \_\_\_\_- \_\_\_\_\_ Sexo: M  F **

**Dirección**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ciudad:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Estado:** \_\_\_\_\_\_\_ **Código Postal:** \_\_\_\_\_\_\_\_\_\_\_\_\_  **Condado:** \_\_\_\_\_\_\_\_\_\_

**Teléfono de Casa:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Celular:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Trabajo:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Correo Electrónico:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Donde podemos dejarle un mensaje?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Estado Civil (Marque uno): Soltero(S) \_\_ Casado(M) \_\_ Divorciado(D) \_\_Viudo(W) \_\_ Otro(O)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Raza(Marque uno): Guero (W) \_\_\_ Negro (B) \_\_\_ Hispano(H) \_\_\_ Asiático(A) \_\_\_Indio (I)\_\_\_ Otra raza: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Trabajador Migrante: No es campesino \_\_\_ Trabajo Temporario \_\_\_ Tiene Hogar\_\_ Vive en la calle/carro\_\_\_ Vive en casa del gobierno \_\_\_ Vive con otra familia \_\_ Vive en refugio\_\_\_ Vive en la calle/carro\_\_\_ Vive en hogar transitorio/temporario\_\_\_**

**Vivo solo \_\_\_\_\_ Como oyó de nuestro servicios? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Necesita Interprete? \_\_\_\_\_\_\_\_\_\_ Retirado? \_\_\_\_\_\_\_\_\_**

**Ocupación: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lugar de empleo: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Eres estúdiate? \_\_\_\_\_ Nombre de la escuela? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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### Rehoboth Life Care Ministries, Inc.

### Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Rehoboth Life Care Ministries, Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by Rehoboth Life Care Ministries, Inc. describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Rehoboth Life Care Ministries, Inc**.** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Rehoboth Life Care Ministries, Inc. privacy officer 3208 U.S Highway 42 N. Byron, Ga. 31008

With this consent Rehoboth Life Care Ministries, Inc. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Rehoboth Life Care Ministries, Inc. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

With this consent, Rehoboth Life Care Ministries, Inc. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Rehoboth Life Care Ministries, Inc. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Rehoboth Life Care Ministries, Inc. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Rehoboth Life Care Ministries, Inc. may decline to provide treatment to me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient’s Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient or Legal Guardian, if applicable Copyright © 2002 Gates, Moore & Company. Used with permission. “The HIPAA Privacy Rule: Three Key Forms.” Bush J. *Family Practice Management*. February 2003:29-33, http://[www.aafp.org/fpm/20030200/29theh.html](http://www.AAFP.org/fpm/20010200/51impl.html)

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**Rehoboth Life Care Ministry (RLCM)**

**CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**RLCM and its staff may talk to the following individuals regarding my condition or course of treatment:**

1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RLCM may leave a message (such as your scheduled appointment day & time) to me to the following phone number(s):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RLCM may contact me through other electronic methods, such as email at the following address:** \_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do Not share** my personal information with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**In case of an emergency please contact:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT SIGNATURE (LEGAL GURADIAN) DATE

By signing above, you hereby consent for RLCM Volunteer Dental Clinic to use or disclose information about yourself (patient) that is protected under federal law. You may refuse to sign this consent form.