AIMS
All Inclusive Medical Services

Phone: (916) 332-1210 Fax: 916-332-0207
5900 Coyle Avenue, Suite A, Carmichael, CA 95608

Welcome to the AIMS Clinic!

We would like to take this opportunity to welcome you to our practice and to thank you for choosing our physicians to participate in your healthcare. We look forward to providing you with personalized, comprehensive healthcare focusing on wellness and prevention. Our providers and staff work closely in a "team approach" to support your healthcare needs.

Our clinic is open Monday through Friday from 8:30am – 5:30pm. Booking an appointment in advance is essential to ensure all patients receive the time they require for quality medical care. Please arrive 30 minutes prior to your first scheduled appointment to complete any necessary paperwork or co-pays. Once established, please arrive 15 minutes early for any return office visits, follow ups, refill appointments, and sick visits **or** 30 minutes early for any annual wellness visits, pre-op, EKG, and pap smear appointments. Failure to arrive within these check-in times will result in cancellation of your appointment. If you are unable to make it to your appointment, please notify us 24 hours in advance. We can be reached at 916-332-1210.

Please complete the enclosed forms and bring them with you to your first appointment. Please bring your health insurance card(s), Photo ID, and medication list, including strength and dose of each medication you are currently taking. Please contact your previous physician and specialists to request copies of your medical records to be sent to us as soon as possible.

Once again, thank you for choosing us as your primary healthcare provider. We look forwards to working with you.

Your Care Team,

AIMS Clinic

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AUTHORIZATION FOR USE AND DISCLOSURE OF PATIENT HEALTH INFORMATION

****PLEASE MAIL RECORDS OVER 20 PAGES****

I Hereby Authorize: (Previous Provider)

_____

_____

Phone: _____

Fax: _____

To Disclose To:

AIMS CLINIC

5900 Coyle Ave., Suite A

Carmichael, CA 95608

Phone: 916-332-1210 / Fax: 913-332-0207

Records and Information Pertaining To:

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date specified below.

Date of records disclosure expiration (if any): _____

REVOCATION: This authorization is also subject to written revocation by the patient at any time.

REDISCLOUSRE: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

RECORDS TO DISCLOSE:

_____ Medical Information

_____ Psychiatric Information

_____ Drug/Alcohol Information

_____ Results of HIV Test

_____ Genetic Records

_____ Other Health Information: _____

The recipient may use the health information authorized on this form for the following purposes:

_____

Signature: _____ Date: _____

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AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS / HEALTH INFORMATION

I authorize All Inclusive Medical Services (AIMS) 'the practice' to obtain any/all medical records concerning my care from any physician, hospital or other healthcare professional that has provided medical care to me in the past.

I also authorize the practice to release any/all medical records concerning my care to any physician, hospital or other healthcare professional providing care to me at any time.

Additionally, I authorize the practice to release any/all medical records concerning my care to Medicare, Medicaid, Medi-Cal, my insurance company, third party administrator or managed care company or health plan.

Signature: _____ Date: _____

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS / HEALTH INFORMATION TO AN INDIVIDUAL OR FAMILY MEMBER(S)

In accordance with Federal Government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of the practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that the rules and restrictions may be waived.

_____ I do **NOT** authorize the practice to release any/all information concerning my medical care to any individual except as set forth above.

_____ I authorize the practice to verbally release any/all information concerning my medical care to the following individual(s):

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICE

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.

(EFFECTIVE JANUARY 1ST, 2019) TOTAL PAGES 5

Patient Name: _____ DOB: _____

All Inclusive Medical Services Inc. – AIMS Inc. Notice of Privacy Practices

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), AIMS Inc. is required by law to maintain the privacy of health information that identifies you, protected health information (PHI), and provide you with notice of your legal duties and privacy practices regarding PHI. AIMS Inc. is committed to the protection of your PHI and will make reasonable efforts to ensure the confidentiality of your PHI, as required by statute and regulation. We take this commitment seriously and will work with you to comply with your right to receive certain information under HIPAA.

AIMS Inc. Use and Disclosure of PHI

As permitted under HIPAA, the following categories explain the types of uses and disclosures of PHI that AIMS Inc. may make. Some of the uses and disclosures described may be limited or restricted by state laws or other legal requirements, for example, The Clinical Laboratory Improvement Amendments of 1988 (CLIA). Please contact our Privacy Officer using the contact information provided at the end of this notice for specific information regarding your state.

- **For Treatment** – AIMS Inc. may use or disclose PHI for treatment purposes, including disclosure to physicians, nurses, medical students, pharmacies, and other healthcare professionals who provide you with healthcare services and or are involved in the coordination of your care, such as providing your physician your laboratory results.
- **For Payment** – AIMS Inc. may use or disclose PHI to bill and collect payment for laboratory or genetic counseling services we provide. For example, AIMS Inc. may provide PHI to your health plan to receive payment for the services rendered to you.
- **For Health Care Operations** – AIMS Inc. may use or disclosure PHI for health care operations purposes. These uses and disclosures are necessary, for example, to evaluate the quality of our laboratory testing, the accuracy of results, accreditation, functions and for AIMS Inc. Operation and management purposes. AIMS Inc. may also disclose PHI to other health care providers or health plans that are involved in your care for their health care operations. For example, AIMS Inc. may provide PHI to manage disease, or o coordinate health care or health benefits.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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- **Appointment Reminders and Health-Related Benefits & Services** – AIMS Inc. may use and disclose PHI to contact you as a reminder that you have an appointment with us and may use and disclose PHI to tell you about health-related benefits and services that may be of interest to you. For example, AIMS Inc. may contact you about a new patient service center in your area or about new testing services available at AIMS Inc. based n services ordered by your physician.
- **To Individuals Involved in Your Care or Payment for Your Care** – AIMS Inc. may disclose PHI to a person who is involved in your care or helps pay for your care, such as a family member or friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort. As allowed by federal and state law, we may disclose the PHI of minors to their parents or legal guardians.
- **Business Associates** – AIMS Inc. may disclose PHI to our business associates to perform certain business functions or provide certain business services to AIMS Inc. For example, we may use another company to perform billing servicers on our behalf. All business associates are required to maintain the privacy and confidentiality of your PHI. In addition, at the request of your health care providers or health plan, AIMS Inc. may disclose PHI to their business associates for the purposes of performing certain business functions or health care services on their behalf. For example, we may disclose PHI to business associate of Medicare for the purposes of medical necessity review and audit.
- **Disclosure for Judicial and Administrative Proceedings** – Under certain circumstances, AIMS Inc. may disclose your PHI over the course of a judicial or administrative proceeding, including in response to a court or administrative order, subpoena, discovery request, or other lawful process.
- **Law Enforcement** – AIMS Inc. may disclose PHI for law enforcement purposes, including reporting of certain types of wounds or physical injuries or in response to a court order, warrant, subpoena, or similar process authorized by law. We may disclose PHI when the information is needed: 1) For identification or location of a suspect, fugitive, material witness or missing person; 2) About a victim or a crime; 3) About an individual who has passed away; 4) In relation to criminal conduct on AIMS Inc. premises; or 5) In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.
- **As Required by Law** – AIMS Inc. must disclose your PHI if required to do so by interventional, federal, state, or local law.
- **Public Health** – AIMS Inc. may disclose PHI for public health activities. These activities generally include: 1) Disclosures to a public health authority to report, prevent or control disease, injury, or disability; 2) Disclosures to report births and deaths, or to report child abuse or neglect; 3) Disclosures to a person subject to the jurisdiction of the Food and Drug Administration (FDA) for the purposes related to the quality , safety, or effectiveness of an FDA-regulated product or activity, including reporting reactions to medications or problems with products or notifying people of recalls of products they may be using; 4) Disclosures to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; or 5) Disclosures to an employer about an employee to conduct medical surveillance in certain limited circumstances concerning workplace illness or injury.
- **Disclosure About Victims of Abuse, Neglect, or Domestic Violence** – AIMS Inc. may disclose PHI about an individual to a government authority, including social services, if we reasonably believe that an individual is a victim of abuse, neglect, or domestic violence.

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- **Health Oversight Activities** – AIMS Inc. may disclose PHI to a health care oversight agency for activities authorized by law such as audits, civil, administrative, or criminal investigations and proceedings/actions, inspections, licensure/disciplinary actions, or other activities necessary for appropriate oversight of the health care system, government benefit-programs, and compliance with regulatory requirements and civil right laws.
- **Coroners, medical Examiners, and Funeral Directors** – AIMS Inc. may disclose PHI to a coroner, medical examiner, or funeral director for the purpose of identifying a deceased person, determining cause of death, or for performing cause of death, or for performing some other duty authorized by law.
- **Personal Representative** – AIMS Inc. may disclose PHI to your personal representative, as established under applicable law, or to an administrator, executor, or other authorized individual associated with your estate.
- **Correctional Institution** – AIMS Inc. may disclose the PHI of an inmate r other individual when requested by a correctional institution or law enforcement official for health, safety, and security purposes.
- **Serious Threat to Health or Safety** – AIMS Inc. may disclose PHI if necessary to prevent or lessen a serious and/or imminent threat to health and safety to a person or the public or for law enforcement authorities to identify or apprehend an individual.
- **Research** – AIMS Inc. may use and disclose PHI for research purposes. Limited data or records may be viewed by researcher(s) to identity patients who may qualify for their research project or for other similar purposes as long as the researcher(s) do not remove or copy any of the PHI. Before we use or disclose PHI for any other research activity, one of the following will happen: 1) A special committee will determine that the research activity poses minimal risk to privacy and that there is an adequate plan to safeguard PHI; 2) If the PHI relates to deceased individuals, the researcher(s) give us assurances that the PHI is necessary for the research and will be used only as part of the research; 3) The researcher(s) will be provided only with information that does not identify you directly.
- **Government Functions** – In certain situations AIMS Inc. may disclose the PHI of Military personnel and veterans, including Armed Forces personnel, as required by military command authorities. Additionally, we may disclose PHI to authorized officials for national security purposes, such as protecting the President of the United States, conducting intelligence, counter-intelligence, other national security activities, and when requested by foreign military authorities. Disclosure will be made only in compliance with U.S. Law.
- **Workers' Compensation** – As authorized by applicable laws, AIMS Inc. may use or disclose PHI to comply with workers' compensation or other similar programs established to provide work related injury or illness benefits.
- **De-identifies Information and Limited Data Set** – AIMS Inc. may use and disclose health information that has been "de-identified" by removing certain identifiers making it unlikely that you could be identified. AIMS Inc. also may disclose limited health information, contained in a "limited data set." The limited data set does not contain any information that can directly identify you. For example, limited data set may include your city, county, zip code, but not your name or street address.

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Other Uses and Disclosures of PHI

For purposes not described above, including uses and disclosures of PHI for marketing purposes and disclosures that would constitute a sale of PHI, AIMS Inc. will ask for your written authorization before using or disclosing your PHI. If you signed an authorization form, you may revoke it, in writing, at any time, except the extent that action has been taken in reliance on the authorization.

Information Breach Notification

AIMS Inc. is required to provide patient notification if it discovers a breach of unsecured PHI unless there is a demonstration, based on a risk assessment, that there is a low probability that PHI has been compromised. You will be notified without unreasonable delay and no later than 60 days after discovery of the breach. Such notification will include information about what happened and what can be done to mitigate any harm.

Patient Rights Regarding PHI

Subject to certain exceptions, HIPAA establishes the following patient rights with respect to PHI:

- **Right to Receive a Copy of the AIMS Inc. Notice of Privacy Practices** – You have a right to receive a copy of the AIMS Inc. Notice of Privacy Practices at ant time by contacting us at 916-332-1210 and asking the AIMD Inc. office manager, or by sending a written request to: Office Manager, AIMS Inc., 5900 Coyle Ave. Suite A, Carmichael, CA 95608.
- **Right to Request Limits on Uses and Disclosures of Your PHI** – You have the right to request that we limit: 1) How we use and disclose your PHI for treatment, payment, and health care operation activities; or 2) Our disclosure of PHI to individuals involved in your care or payment for your care. AIMS Inc. will consider your request, but is not required to agree to it unless the requested restriction involves a disclosure that is not required by law to a health plan for payment or health care operation purposes and not for treatment, and you have paid for the service in full out of pocket. If we agree to a restriction on any other types of disclosures, we will state the agreed restrictions in writing and will abide by them, except in emergency situations when the disclosure is for purposes of treatment.
- **Right to Request Confidential Communication** – You have the right to request that AIMS Inc. communicate with you about your PHI at an alternative means. AIMS Inc. will accommodate reasonable requests.
- **Right to See and Receive Copies of Your PHI** – You and your personal representative have the right to access PHI consisting of your laboratory test results or reports ordered by your physician. Within 30 days after our receipt of your request, you will receive a copy of the completed laboratory report from AIMS Inc. unless an exception applies. Exceptions include our inability to verify the identity of the requesting party, our inability to provide access to the PHI within 30 days, in which case we may extend the response time for an additional 30 days if we provide you with a written statement of the reasons for the delay and the date by which access will be provided. You have the right to access and receive PHI in an electronic format if it is readily producible in such a format. You also have the right to direct AIMS Inc. to transmit a copy to another person you designate, provided such request is in writing, signed by you, and clearly identifies the designated person and where to send the copy of your PHI. To request a copy of your PHI please refer to the following address:

AIMS Inc.
5900 Coyle Ave. Suite A,
Carmichael, CA 95608
PH: 916-332-1210 / FAX: 916-332-0207

- **Right to Receive and Accounting Disclosures** – You have the right to receive a list of certain instances in which AIMS Inc. disclose your PHI. The list will not include certain disclosures of PHI, such as (but limited to) those made based on your written authorization or those made prior to the date on which AIMS Inc. was required to comply. If you request an accounting of disclosures of PHI that were made for the purposes of treatment, payment or health care operations, the list will include only those disclosures made in the past three years for which an accounting is required by law, unless your request a shorter period of disclosures.
- **Patient Right to Access Records** – Patients have the right to access their records by sending a written request to:

AIMS Inc., 5900 Coyle Ave. Suite A, Carmichael, CA, 95608

Patients have the right to lodge complaints to the AIMS Compliance Office, Angie Fuher, at 916-332-1210 and to the Office of Civil Rights if their rights have been violated under any applicable law.

You may contact the Office of Civil Rights at:

Website: OCRportal.hhs.gov

Mailing Address: U.S Department of Health and Human Services

200 Independence Avenue, S.W.

Washington, D.C. 20201

Email: ocrcomplaint@hhs.gov

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NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____ **DOB:** _____

Allergies ☐ No Allergies

ALLERGY	ALLERGIC REACTION

Medications ☐ No Medications

Pharmacy: _____

MEDICATIONS (Please list ALL)	DOSE (Mg., pill, etc)	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information.

Health Maintenance Screening Test History

LIPIDS/CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY/COLOGUARD	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	Date:	Facility/Provider:	Abnormal Result? Y N

Vaccination History

Last Tetanus Booster or TdaP:	Last Pneumovax (*Pneumonia*):
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine (*Shingles*):	COVID Vaccine:

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Patient Name: _____ **DOB:** _____

Personal Medical History

DISEASE/CONDITION	CURRENT (Mark with X)	PAST (Mark with X)	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type: _____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type: _____)*			
Emphysema (COPD)			
Heart Attack			
High Blood Pressure *(Hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(Kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

Surgeries

TYPE *(Specify left/right)*	DATE	LOCATION/FACILITY

Women's Health History

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

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Patient Name: _____ **DOB:** _____

Family Medical History

☐ No Significant Family History

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	Other: ____	Other: ____	Deceased / Alive (Circle one)
Mother																		D / A
Father																		D / A
Sister																		D / A
Brother																		D / A
Child																		D / A
Maternal Grandmother																		D / A
Maternal Grandfather																		D / A
Paternal Grandmother																		D / A
Paternal Grandfather																		D / A
Other: _____																		D / A

Social History

TOBACCO USE	Do You Smoke Cigarettes? Y N (*if you never smoked, please move to Alcohol/Drug Use*)		
Current: Packs/Day _____ # of Years _____		**Past:** Quit Date: _____ Packs/Day _____ # of Years ____	
Other Tobacco *(Check all that apply):* ☐Pipe ☐Cigar ☐Snuff ☐Chew			
Do you use E-Cigaretes? Y N		Do you use a Vape? Y N	
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	☐ Beer ☐ Wine ☐ Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N		Have you ever used marijuana or recreational drugs? Y N	
Have you ever taken someone else's drugs? Y N		Have you ever used needles to inject drugs? Y N	

Other Providers/Specialists

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other: _____		

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Staying Healthy Assessment

Adult

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(If patient needs help)*	☐ Family Member ☐ Friend ☐ Other (*Specify*)		Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
					Nutrition
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Are you concerned about your weight?	No	Yes	Skip	
					Physical Activity
8	Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day?	Yes	No	Skip	
					Safety
9	Do you feel safe where you live?	Yes	No	Skip	
10	Have you had any car accidents lately?	No	Yes	Skip	
11	Have you been hit, slapped, kicked, or physically hurt by someone in the last year?	No	Yes	Skip	
12	Do you always wear a seat belt when driving or riding in a car?	Yes	No	Skip	
13	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
					Dental Health
14	Do you brush and floss your teeth daily?	Yes	No	Skip	
					Mental Health
15	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	
16	Do you often have trouble sleeping?	No	Yes	Skip	
					Alcohol, Tobacco, Drug Use
17	Do you smoke or chew tobacco?	No	Yes	Skip	
18	Do friends or family members smoke in your house or place where you live?	No	Yes	Skip	

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19	In the past year, have you had: ☐ (men) 5 or more alcohol drinks in one day? ☐ (women) 4 or more alcohol drinks in one day?	No	Yes	Skip	
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
					Sexual Issues
21	Do you think you or your partner could be pregnant?	No	Yes	Skip	
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
23	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
24	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
25	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
26	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
					Other Questions
27	Do you have other questions or concerns about your health?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	**Print Name:**	**Date:**
SHA ANNUAL REVIEW		
PCP's Signature:	**Print Name:**	Date:
PCP's Signature:	**Print Name:**	**Date:**
PCP's Signature:	**Print Name:**	**Date:**
PCP's Signature:	**Print Name:**	**Date:**

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PATIENT HEALTH QUESTIONNARIE (PHQ-2)

Patient Name: _____ DOB: _____

Date: _____

Over the last two weeks, how often have you been bothered by the following problems?

(Circle the most accurate description)

1. Little interest or pleasure in doing things:

Not at All (0) Several Days (+1) More Than Half the Days (+2) Nearly Every Day (+3)

2. Feeling down, depressed, or hopeless:

Not at All (0) Several Days (+1) More Than Half the Days (+2) Nearly Every Day (+3)

For Providers Use Only:

Score: _____

PHQ-9 Form Given? YES NO

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