18 de Enero, 2015

# DERECHOS Y RESPONSABILIDADES DEL PACIENTE

Project HOME Healthcare Services (PHHS o Servicios de Salud de Project HOME) se esfuerza en dar servicios de salud extensiva y de orientación preventiva. Para facilitar mejores canales de comunicaciónon, mejoramiento de relación entre paciente y proveedor y atender pacientes más eficientemente, PHHS presenta y publica visiblemente en todos sus sitios los siguientes derechos para los pacientes, clientes y sus familias.

**Como paciente tengo derecho a:**

- Que mi dolor sea asesorado y atendido.
- Recibir información acerca de medicamentos incluyendo: ¿Para qué es? ¿Cuánto debo de tomar y por cuánto tiempo? ¿Qué efectos secundarios puede tener?
- Ser asignado un proveedor primario.
- Tener un miembro de mi familia o amigo que pueda hablar por mí y me ayude a lograr lo que necesito.
- Ser informado por qué es necesario hacerme un análisis o tratamiento y como esto me beneficiara.
- Ser informado sobre los resultados de un análisis.
- Recibir en lenguaje que yo entienda información adecuada de mi proveedor de salud, acerca de mi diagnosis y pertinente tratamiento. En caso que yo no quiera seguir el tratamiento, seré informado de las consecuencias médicas.
- En ciertas ocasiones otra facilidad puede tener servicios que PHHS no tiene. Yo puedo ser referido a esa facilidad después que me hayan dado toda la información necesaria.
- Tener consideración personal, respetable y razonable y que toda información de mi persona sea confidencial.
- Saber los nombres y títulos del proveedor de salud que me de tratamiento.
- Ser informado sobre las pólizas, procedimientos, honorarios y gastos de servicio de PHHS.
- Recibir una cita que sea conveniente para mí. No deberé tener que esperar mucho tiempo para una cita sin una explicación.
- Recibir una explicación de mi factura o cuenta.
- Ser oído si tengo alguna sugerencia o queja.
- Tener mi dignidad como paciente respectado.

Están bienvenidas todos las personas a recibir servicios en PHHS sin debido a la raza, religión o credo, discapacidad, sexo, orientación sexual, identidad de género, edad, origen nacional o ancestro, ciudadanía, o estado de veterano.

**Como paciente usted es responsable de:**

- Proveer información a mi proveedor acerca de enfermedades pasadas, hospitalizaciones, y medicamentos, incluyendo recetas, medicamentos sin receta, vitaminas, hierbas, u cualquier otra cosa relacionada a mi salud.
- Informar a mi proveedor acerca de cualquier alergia o reacción adversa que haya tenido con medicamentos.
- Informar a mi proveedor acerca de problemas presentes o pasados relacionados con mi salud, incluyendo pero no limitado a problemas de salud mental o problemas con el abuso de medicamentos para el dolor.
- Cooperar con todo el personal clínico y hacer preguntas si no entiendo algo.
- Ayudar a mi proveedor medico en sus esfuerzos para darme cuidado de salud, siguiendo sus instrucciones y ordenes médicas.
- Respetar la propiedad de otros y la propiedad de PHHS.
- Venir a las citas o informar PHHS lo más pronto posible si no puedo cumplir con las mismas.
- Dar la informaciónon necesaria para que PHHS colecte facturas de mi seguro médico y aceptar que yo tengo la responsabilidad de pagar por mi factura o cuenta. Si mi cuenta o factura esta incorrecta, PHHS corregirá la factura o cuenta. Se espera de mí que pague mi cuenta o factura cuando PHHS lo pida.
- Traer mi tarjeta de identificación de seguro médico, tarjeta corriente del Medicare o Medicaid o cualquier otra información necesaria, a cada visita que haga a PHHS.
- Informar al Centro cuando haya cambios de dirección, de miembros del hogar, o de mi estatus financiero.

Exigimos a que los pacientes apliquen para cualquier beneficio de salud a lo cual sean intitulado.

**Qué hacer si no tengo seguro médico?**

Project HOME/Stephen Klein Wellness Center es un Centro de Salud Federalmente Calificado (FQHC). Este quiere decidir que Project HOME/Stephen Klein Wellness Center puede mandar los cuentos a los planes de seguro médico, y que también tiene algunos recursos más para ayudar a los que no tienen seguro médico.

Aquí hay algunas pólizas que la gente que no tengan seguro médico deberían saber:

- Los empleados del Stephen Klein Wellness Center pedirán a los pacientes que no tengan seguro médico que paguen una cuota.
- La cantidad de la cuota es determinada por el ingreso y el tamaño de la familia del paciente.
- La recepcionista que le ayude con la registración tendrá que saber su ingreso anual para determinar la cuota correcta.
- Para calificar para la escala de descuento, los pacientes deben llenar una aplicación para el escala de descuento y proveer documentación del ingreso de la familia.
- Pediremos que cumple una aplicación para la escala de descuento cada ano.
- Muy Importante: Proveeremos los mismos servicios de alta calidad, aunque alguien no pueda pagar todo o ningún parte de su cuota en el día de su visita. No le rechazaremos por una falta habilidad de pagar.

Ademas que la aplicación de la escala de descuento, nuestros empleados pueden ayudar con los siguientes servicios financieras:

- Cumplir una aplicación para la Asistencia Médica por el departamento del bienestar público.
- Aplicar por un subsidio del gobierno por el Acto del Cuido Asequible (a.k.a. Obamacare or www.healthcare.gov).

Funded by HRSA

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.**

## A. OUR COMMITMENT TO YOUR PRIVACY

Project HOME is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this Notice of Privacy Practices ("Notice") that we maintain in Project HOME concerning how we may use or disclose your PHI. By federal and state law, we must follow the terms of the Notice that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

**Changes to this Notice.** The terms of this Notice apply to all records containing your PHI that are created or retained by Project HOME. We reserve the right to revise or amend this Notice. Any revision or amendment to this Notice will be effective for all of your records that Project HOME has created or maintained in the past, and for any of your records that we may create or maintain in the future. Project HOME will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

## B. WHO TO CONTACT FOR FURTHER INFORMATION:

If you have questions about this Notice, requests or complaints related to the permitted or required uses and disclosure of your PHI by Project HOME and your rights with respect to your PHI to please contact:

Monica Medina McCurdy, Vice President, Healthcare Services and Privacy Officer, 1845 N. 23rd Street, Philadelphia, PA 19121, 215-235-3110 ext. 5614; or

Psychiatric Rehabilitation Services, attn: Gillian Raskin, 1515 Fairmount Avenue, Philadelphia, PA 19130.

## C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI.

**1. Treatment**. Many of the people who work for Project HOME – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We may use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you.

**2. Payment**. Project HOME may use and disclose your PHI in order so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment.

**3. Health Care Operations**. Project HOME may use and disclose your PHI to operate our business. Project HOME may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for Project HOME. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

**4. Appointment Reminders**. Project HOME may use and disclose your PHI to contact you and remind you of an appointment.

**5. Treatment Options**. Project HOME may use and disclose your PHI to inform you of potential treatment options or alternatives.

**6. Health-Related Benefits and Services**. Project HOME may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

**7. Release of Information to Family/Friends**. Project HOME may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take a child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

**8. Disclosures Required By Law**. Project HOME will use and disclose your PHI when we are required to do so by federal, state or local law.

## D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

**1. Business Associates.** We may share your PHI with certain business associates that perform services for us so that they can perform the job we have asked them to do. For example, we may use another company to perform billing services on our behalf. To protect your PHI, we require the business associate to appropriately safeguard the PHI.

**2. Public Health Risks**. Project HOME may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

**3. Health Oversight Activities**. Project HOME may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

**4. Lawsuits and Similar Proceedings**. Project HOME may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain a court or administrative order protecting the requested PHI.

**5. Law Enforcement**. We may release PHI if asked to do so by a law enforcement official: (a) regarding a crime victim in certain situations, if we are unable to obtain the person's agreement; (b) concerning a death we believe has resulted from criminal conduct; (c) regarding criminal conduct at our offices; (d) in response to a warrant, summons, court order, subpoena or similar legal process; (e) to identify/locate a suspect, material witness, fugitive or missing person; and (f) in an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

**6. Deceased Patients**. Project HOME may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

**7. Organ and Tissue Donation**. Project HOME may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to

facilitate organ or tissue donation and transplantation if you are an organ donor.

**8. Serious Threats to Health or Safety**. Project HOME may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. For example, Project HOME may share your PHI (including details of your COVID-19 test status, test results and symptoms) with staff at our residences so they can implement protocols to protect the health and safety of staff and other residents.

**9. Military**. Project HOME may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

**10. National Security**. Project HOME may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

**11. Inmates**. Project HOME may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

**E. YOUR RIGHTS REGARDING YOUR PHI**

**12. Workers' Compensation**. Project HOME may release your PHI for workers' compensation and similar programs.

You have the following rights regarding the PHI that we maintain about you:

**1. Confidential Communications**. You have the right to request that Project HOME communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request the Privacy Officer or to Psychiatric Rehabilitation Services at the addresses listed at the beginning of this Notice, specifying the requested method of contact, or the location where you wish to be contacted. Project HOME will accommodate **reasonable** requests. You do not need to give a reason for your request.

**2. Requesting Restrictions**. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Privacy Officer or to Psychiatric Rehabilitation Services at the addresses listed at the beginning of this Notice. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit Project HOME's use, disclosure or both; and
(c) to whom you want the limits to apply.

**3. Inspection and Copies**. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. To inspect or copy PHI about you, you must submit your request in writing to the Privacy Officer or to Psychiatric Rehabilitation Services at the addresses listed at the beginning of this Notice. Project HOME may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Project HOME may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

**4. Amendment**. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for Project HOME. To request an amendment, you must submit your request in writing to the Privacy Officer or to Psychiatric Rehabilitation Services at the addresses listed at the beginning of this Notice. You must provide us with a reason that supports your request for amendment. Project HOME will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by Project HOME, unless the individual or entity that created the information is not available to amend the information.

**5. Accounting of Disclosures**. All of our patients have the right to request a list of certain non-routine disclosures Project HOME has made of your PHI. This includes uses or disclosures for purposes other than treatment, payment, health care operations, disclosures made directly to you or for which you have provided written authorization. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer or to Psychiatric Rehabilitation Services at the addresses listed at the beginning of this Notice. All requests for an accounting of disclosures must state a time period, which may not be longer than six (6) years from the date of disclosure or include dates before April 14, 2003. Your first request within a 12-month period is free of charge, but Project HOME may charge you for additional lists within the same 12-month period. Project HOME will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

**6. Right to a Paper Copy of This Notice**. You are entitled to receive a paper copy of the Notice, even if you have agreed to receive the Notice electronically. You may ask us to give you a copy of this Notice at any time. To obtain a paper copy of this Notice, contact the Privacy Officer or Psychiatric Rehabilitation Services at the addresses listed at the beginning of this Notice.

**7. Right to File a Complaint**. If you believe your privacy rights have been violated, you may file a complaint with Project HOME or with the Secretary of the Department of Health and Human Services. To file a complaint with Project HOME, contact the Privacy Officer or Psychiatric Rehabilitation Services at the addresses listed at the beginning of this Notice. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

**8. Right to Provide an Authorization for Other Uses and Disclosures**. Project HOME will obtain your written authorization for uses and disclosures that are not identified by this Notice or permitted by applicable law. Your authorization is required for any use or disclosure of PHI for marketing communications or the sale of PHI that involves financial payment to Project HOME. You may revoke an authorization at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the purposes described in the authorization. Please note that we are required to retain records of your care.

**9: State Laws on the Privacy of Certain Health Information.** Pennsylvania provides special privacy protections for particularly sensitive conditions or illnesses such as HIV/AIDS, mental health, and substance abuse.

**HIV/AIDS:** We will not disclose any HIV- related information, except in situations where the subject of the information has provided us written consent allowing the release or where we are authorized or required by law to make the disclosure.

**Mental Health:** Any records related to involuntary mental health treatment (inpatient or outpatient) or voluntary inpatient treatment will not be disclosed without your written consent. Any mental health information disclosed will be limited to relevant information necessary for the purpose for which the information is sought.

**Drug/Alcohol Abuse Treatment:** We will not disclose any information related to drug and/or alcohol abuse treatment without your written authorization. Even with written authorization, we will only release such information under the following circumstances: (a) to medical personnel exclusively for the purposes of treatment or diagnosis; or (b) to government or other officials exclusively for the purpose of obtaining benefits due to you as a result of drug or alcohol abuse.

We may release information related to drug and/or alcohol abuse treatment under the following circumstances: (a) in emergency medical situations where your life is in immediate danger and the information is released solely for the purpose of providing medical treatment; and (b) in response to a court order.

**F. EFFECTIVE DATE.**

This Notice is effective as of September 25, 2013.

PROJECT HOME
HOUSING | OPPORTUNITIES | MEDICAL | EDUCATION
STEPHEN KLEIN WELLNESS CENTER

# Registro del Paciente

Fecha de Hoy: ____/____/____
mm dd año

**Nombre:** _____
Apellido Nombre Segundo Nombre

**Numero de Seguro Social:** _____ **Fecha de Nacimiento:** ____/____/____ **Sexo:** ☐H ☐M ☐_____
mm dd año

**Dirección de casa:** _____ **# de Teléfono preferido:** (____) _____
☐Casa ☐Trabajo ☐Celular

_____

**Otro Teléfono:** (____) _____
☐Casa ☐Trabajo ☐Celular

_____
Cuidad Estado Código Postal

**Correo Electrónico:** _____

**Raza:** ☐Afroamericano/Negro ☐Blanco ☐Asiático ☐Otro _____ **Etnicidad:** Hispano/Latino? ☐Sí ☐No

**Idioma preferido:** _____

**Veterano?** ☐Sí ☐No **Es registrado para votar con su dirección?** ☐Sí ☐No

**Ingreso Familiar Aproximado? $**_____ **semanal/mensual/anual**

**Cuantas personas hay en la familia o casa?:**_____

**Cual es su estado de vivienda?(**elige uno**):**
- ☐Calle o carro
- ☐Hogar de transición/témpora
- ☐Propio hogar o apartamento
- ☐Refugio
- ☐Otro _____

**Cual seguro tiene Ud.?**
- ☐Ninguno
- ☐Keystone First
- ☐Health Partners
- ☐Medicare
- ☐Otro _____

**Preferencia de la comunicación:**
- ☐Necesito interprete
- ☐Mudo
- ☐Discapacidad visual
- ☐Sordo

**Estado de trabajador migratorio:**
- ☐No trabajo en granja
- ☐Trabajo en algunas estaciones
- ☐Me he trasladado para buscar trabajo en granjas

**Contacto de emergencia:** _____
Apellido Nombre Relación

Teléfono: _____ Dirección: _____

☐Casa ☐Trabajo ☐Celular _____

**Como fue que Ud. descubrió nuestra clínica?** _____

**Favor de seleccionar la respuesta que Ud. prefiere cuando no podemos comunicarnos con Ud. directamente:**
- ☐ No deje un recado en mi teléfono.
- ☐ Deje un recado en mi teléfono.
- ☐ Deje un recado con cualquier persona que conteste me teléfono.

_____ _____
***Firma del paciente o de la persona responsable*** ***Fecha***

*Rev. 11/17*

COMMUNITY HEALTH CENTER FQHC QUALITY

PROJECT HOME
HOUSING | OPPORTUNITIES | MEDICAL | EDUCATION
STEPHEN KLEIN WELLNESS CENTER

## Consentimiento al tratamiento y reconocimiento de las prácticas de la privacidad

**Nombre:**_____ **Fecha de Nacimiento**_____

En firmar abajo:

- Presto mi consentimiento para recibir tratamientos rutinas y procedimientos que mis proveedores médicos, dentales y del salud del comportamiento creen que mejorara mi salud. Tratamientos rutinas y procedimientos incluye, pero no son limitados a, preguntarme acerca de me salud física, mental y la historia médica; hablar sobre mis preocupaciones y problemas, un examen física, prescribir medicinas, y administrar tratamientos. Yo entiendo que mis proveedores trabajaran conmigo para diagnosticar y tratar mis problemas del salud. **En cualquier momento, yo tengo el derecho de rechazar el tratamiento.** (Hay más información sobre los derechos y responsabilidades en "Los Derechos de los Pacientes").
- Presto mi consentimiento al intercambio de información de medicación prescrito por e-prescripción para la continuidad del cuidado.
- Yo reconozco el recibo de "Aviso de las prácticas de la privacidad" por Project HOME.
- Entiendo que yo soy responsable por todos las cuotas cargados para mis tratamientos, aunque no sean cubiertos por mis beneficios del seguro.

_____ _____

Firma del paciente o el representante personal Fecha

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**OFFICE USE ONLY**

*Inability to obtain acknowledgement:*

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the reasons why the acknowledgement was not obtained.

- ☐ Individual refused to sign.
- ☐ Communications barriers prohibited the ability to obtain the acknowledgement.
- ☐ An emergency situation prevented us from obtaining the acknowledgement.
- ☐ Other (please specify):

_____

Signature of Project HOME Representative Date

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HOUSING | OPPORTUNITIES | MEDICAL | EDUCATION
STEPHEN KLEIN WELLNESS CENTER

**Nombre del Paciente:**_____ **Fecha de Nacimiento:**_____/_____/_____
Apellido Nombre mes día año

**Cual es su apodo?:**_____ **Identidad de Género:**_____ **Sexo Asignado al nacer:**_____

**Historial De Salud**: Tiene, o ha tenido Ud. alguno de lo siguiente?

| Condición | Fecha del diagnosis | Condición | Fecha del diagnosis | Condición | Fecha del diagnosis |
|---|---|---|---|---|---|
| ☐ Diabetes | _____ | ☐ Carrera | _____ | ☐ Estrés postraumático | _____ |
| ☐ Alta presión de la sangre | _____ | ☐ Reflujo acido | _____ | ☐ Depresión | _____ |
| ☐ Colesterol Alto | _____ | ☐ Enfermedad del riñón | _____ | ☐ Ansiedad | _____ |
| ☐ Asma | _____ | ☐ Enfermedad de tiroides | _____ | ☐ Trastorno bipolar | _____ |
| ☐ Alergia | _____ | ☐ Neumonía | _____ | ☐ Esquizofrenia | _____ |
| ☐ Enfisema/EPOC | _____ | ☐ Cáncer | _____ | ☐ Otro (escribe) | |
| ☐ Tuberculosis | _____ | ☐ VIH/SIDA | _____ | _____ | _____ |
| ☐ Enfermedad del corazón | _____ | ☐ Anemia | _____ | ☐ _____ | _____ |

**Asistencia con comida**

Project HOME tiene una despensa de alimentos por emergencia. Tal existe para los pacientes que tengan dificultades en procurar o comprar comidas últimamente. Nuestros proveedores de salud puedan ayudarte.

1. Dentro de los últimos 12 meses pasados, hemos preocupados por si nuestra comida fuera a acabar antes de que tuviéramos dinero para comprar más. NO SI

Rodee "❍"su respuesta:

| Durante de las ***últimas 2 semanas***, que tan seguido ha tenido molestias por cualquiera de las siguientes dificultades?: | **Nunca** | **Algunos días** | **Mas que la mitad de los días** | **Casi cada día** |
|---|---|---|---|---|
| 1. Poco interés o placer en hacer cosas | 0 | 1 | 2 | 3 |
| 2. Sintiéndose decaído(a), deprimido(a) o sin esperanzas | 0 | 1 | 2 | 3 |
| 3. Sintiéndose nervioso(a) o ansioso(a) | 0 | 1 | 2 | 3 |
| 4. Sintiéndose sin poder para parar o controlar la preocupación | 0 | 1 | 2 | 3 |

| | | |
|---|---|---|
| 5. Durante del año pasado ha tomado o usado drogas más que lo que quería? | Yes | No |
| 6. Ha sentido que Ud. quería o tenia que parar su uso de alcohol o uso de drogas en el ultimo ano? | Yes | No |
| 7. Mucha gente ha pensado que estarían mejores muertos. Ha Ud. tratado de tomarse la vida? | Yes | No |
| 8. Cuando sienten estresado o enojados, alguna gente hacen cosas que después lamentan. Ha Ud. alguna vez pegado, estrangulado, golpeado o dañado por otro método a su pareja? | Yes | No |
| 9. Durante el ultimo ano, ha Ud. controlado a su pareja para controlar a donde va, con quien habla, o como gasta su dinero? | Yes | No |
| 10. Durante el ultimo ano, ha sido Ud. pegado, estrangulado, golpeado o dañado por otro método por su pareja? | Yes | No |
| 11. Durante el ultimo ano, ha sido contralado por su pareja para controlar a donde va, con quien habla, o como gasta su dinero? | Yes | No |
| 12. Siente Ud. en peligro por su pareja? Siente Ud/ en peligro por una pareja del pasado? | Yes | No |

**TURN OVER TO COMPLETE THE OTHER SIDE**

**Antecedentes Quirúrgicos :** (Apunte las fechas en este espacio)

_____

_____

_____

**Hospitalizaciones/Emergencias:** ( Apunte las fechas en este espacio )

_____

_____

_____

**Frecuencia del uso de Tabaco:** ☐ Nunca ☐ Anteriormente:
Fecha de dejar_____

☐ Fumo: cartones/día_____# años_____

**Uso de alcohol:** ☐ No ☐ Sí #bebidas/semana_____

**Uso de drogas recreativas:** ☐ No ☐ Sí
Tipo:_____

**Hay arma en la casa?:** ☐ No ☐ Sí

**Tiene testamento vital?:** ☐ No ☐ Sí

**Ocupación:_____**

**Empleador:_____**

**Estado Civil:_____**

**Nombre de pareja:_____**

**Nombres e edades de los hijos:_____**

_____

**Historia de la Familia:** Incluye la madre, padre, y hermanos. Favor de apuntar a todos los que apliquen y apuntar a cual miembro de la familia le afecta.

- ☐ Alta presión de la sangre _____
- ☐ Enfermedad del corazón _____
- ☐ Cáncer_____
- ☐ Diabetes_____
- ☐ Carrera _____
- ☐ Enfermedad de tiroides_____
- ☐ Enfermedad de la sangre_____
- ☐ Enfermedad Genético_____

**Historia Psicosocial:** (Apunte cualquier tratamiento psiquiátrica, psicológica, o abuso de sustancias con el tipo tratamiento y las fechas)

_____

_____

_____

_____

**Exámenes de salud:**

| Cuándo fue la última: | Fecha: |
|---|---|
| ☐ Chequeo de diabetes | _____ |
| ☐ Chequeo del colesterol | _____ |
| ☐ Colonoscopia | _____ |
| ☐ Chequeo de la SIDA/VIH | _____ |

**<u>Para personas asignadas mujeres al nacimiento:</u>**
Está usando contraceptivo? Qué tipo?_____

| Cuando fue su ultimo: | Fecha: |
|---|---|
| ☐ Periodo menstrual? | ___/____/____ |
| ☐ Prueba de Papanicolaou | ___/____/____ |
| ☐ Mamografía | ___/____/____ |

**Medicaciones:** Apunte medicaciones de prescripción y sin prescripción, contraceptivo, vitaminas, remedio de la casa, hierbas, etc.

Nombre de la medicina Dosis Cuántas veces al día?

_____

_____

_____

**Allergies:** (please list any drug and food allergies) ☐ None ☐ Yes_____ **Latex Allergy** ☐ No ☐ Yes

PROJECT HOME
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# Authorization for Disclosure of Health Information

| **INFORMATION ABOUT THE PATIENT OR CLIENT** | | |
|---|---|---|
| *Patient/Client Name | *Date of Birth | Record Number |
| *Address | Telephone | *Last four digits of SSN |

**PURPOSE OF THIS FORM (*please check one or both)**

- ☐ I would like Project HOME to **release** some of my health information to the following person or institution:
- ☐ I would like Project HOME to **receive** some of my health information from the person or institution:

*Name of Person or Institution:

*Address

| *City/State/Zip Code | Telephone | Fax |
|---|---|---|
| | | |

**INFORMATION TO BE DISCLOSED (*please check all that apply)**

- ☐ Case management progress notes and service plans
- ☐ Medical history and physical examination
- ☐ Medical progress notes and treatment plans
- ☐ In-patient hospital records
- ☐ Emergency department records
- ☐ Radiology reports (x-rays, cat scans, MRIs, etc).
- ☐ Lab reports
- ☐ Psychotherapy Notes and treatment plans
- ☐ Billing records
- ☐ Other (please specify): _____

Covering the period(s) of: _____

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I further understand that information in response to this request may be related to diagnosis or treatment for HIV/AIDS, psychiatric care and treatment, and treatment for drug and alcohol abuse, which may **NOT** be re-disclosed by the recipient without my express written consent. **Please check the appropriate box(es) below:**

| *AIDS/HIV Information | *Psychiatric Care/Treatment | *Treatment for Drug & Alcohol Abuse/Dependence |
|---|---|---|
| ☐ Yes, if applicable, okay to disclose | ☐ Yes, if applicable, okay to disclose | ☐ Yes, if applicable, okay to disclose |
| ☐ No, do not disclose | ☐ No, do not disclose | ☐ No, do not disclose |

| | |
|---|---|
| Please mail/fax requested information to:<br>**Project HOME Healthcare Services**<br>**2144 Cecil B. Moore Ave, Philadelphia, PA 19121** | **Fax: 215-236-2308**<br>**Phone: 215-320-6187**<br>**Please MAIL all large medical records** |

**AUTHORIZATION (*please check one)**

Length of authorization:

- ☐ 1 year from date of authorization
- ☐ Other date – please specify (not to exceed one (1) year from date of authorization): _____

By signing below, I authorize Project HOME and/or Person or Institution named above to release my health information as detailed herein:

_____

*Signature of Patient/Client or Personal Representative  Print Name  Date

*If this Authorization is signed by someone other than the patient or client, please state reason (i.e. person is a minor):

_____

**REVOCATION INFORMATION**

I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing to the address below. I understand that the revocation may not apply to information that has already been released in response to this authorization.

*Send your revocation to: Project HOME, Privacy Officer, 1515 Fairmount Avenue, Philadelphia, PA 19130.*