OXNARD FAMILY CIRCLE
ADULT DAY HEALTH CARE CENTER
2100 Outlet Center Dr. #380, Oxnard CA 93036
Phone: (805) 385-4180 FAX: (805) 751-4149

Medical Assessment and Medication Taken

(could be returned by fax: 805-751-4149 or email: enrollment@oxnardfamilycircle.com)

Patient Name:	Telephone:
Address:	Female ☐ Male ☐
City/State/Zip	Age: DOB:

*****TB Clearance** (within the last 12 months): *Required prior to Patient attending the ADP****

Date of test: _____ ☐ Negative ☐ Positive

Method: ☐ PPD Test ☐ Chest X-Ray

I approve an order for the RN to administer a PPD test at Oxnard Family Circle: ☐ Yes ☐ No

Any indication of communicable disease: ☐ Yes ☐ No

Primary DX:
Secondary DX:

ALLERGIES? ☐ No ☐ Yes _____

DIET AND NUTRITION:

☐ Prudent/Diabetic (low fat, low cholesterol, low sodium, high fiber, NCS) ☐ Puree ☐ Chopped

☐ Renal (low potassium, low phosphorous, low sodium, limited protein)

Special problems and needs:

_____

_____

Ambulatory status, Physical restrictions:

_____

Other:

_____

_____

☐ See Attachments_____

Medication Taken (Please list medications below or mark the box for attachments) ☐ See Attachments

Date Ordered	Medication & Dosage	Route	Frequency	Diagnosis

Physician or Designee Signature:	Date:

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HIPAA Privacy Authorization Form

Effective Date: _____

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Pans 160 and 164)

1. Authorization. I, _____, authorize _____ to use and disclose to protected health
(name of healthcare provider)
information described below to a business entity known as Oxnard Family Circle ADHC.

2. Effective Period. This authorization for release of information covers all past, present, and future periods of health care.

3. Extent of Authorization. I authorize the release of my complete health record (including records related to mental healthcare, communicable diseases, HIV or AIDS, treatment of alcohol or drug abuse).

4. Use. This medical information may be used by the entity I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. Termination. This authorization shall be in force and effect until the date of _____, at which time this authorization form expires.

6. Revocation Rights. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. Benefits. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. Disclosure. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Participant's Name _____Signature _____
(or **Personal Representative**)

Date _____