cpacs cosmo health center
center for pan asian community services

신규 환자 등록서 New Patient Intake Form

환자 정보 PATIENT INFORMATION

이름 Name: _____ *나이 Age:* _____
(성)Last (이름)First (중간이름)Middle Initial

생년월일 (달/일/년): _____/_____/_____ *소셜번호* (선택사항): _____
Date of birth: (mm/dd/yyyy): ***SSN*** (*Optional*)

거리주소 StreetAddress: _____

*시 City:*_____ *주 State* :_____ *우편번호 Zip*: _____

집 전화 Home phone: (_____)_____ *휴대폰 Cell phone* : (_____)_____

이메일 E-mail: _____@_____

성별:Gender
☐ 남성 Male
☐ 여성 Female
☐ 트랜스젠더 Transgender
☐ 그 외, 특정 하십시요: _____
Other, please specify:
☐ 밝히지 않음 Choose not to disclose

성적 취향:Sexual Orientation:
☐ 이성애자 (이성취향) Straight (Heterosexual)
☐ 양성애자 Bisexuality
☐ 동성애자 Homosexuality
☐ 그 외 Something else
☐ 알지 못함 Do not know
☐ 밝히지 않음 Choose not to disclose

결혼 여부 Marital Status:
☐ 독신 Single
☐ 기혼 Married
☐ 이혼 Divorced
☐ 미망인 Widowed

당신은 (해당항목 모두 체크):
Are you a (check all that apply):
☐ 이주노동자 Migrant worker
☐ 계절노동자 Seasonal worker
☐ 재향군인 Veteran
☐ 노숙자 Homeless
☐ 공공주택 거주 Public housing

*히스패닉이거나 라틴계 입니까***?**

Are you ***Hispanic*** *or* ***Latino*****?**

(쿠바,멕시코,푸에르토리코,남미,중미 또는 다른 스페인 계통)

(Cuban, Mexican, Puerto Rican, South or Central American, other Spanish origin)

☐ 예 Yes

☐ 아니오 No

☐ 밝히지 않음 Refused to Report

월별 가계 수입

Monthly Household Income:

☐ $0–1,000

☐ $1,001–2,000

☐ $2,001–3,000

☐ $3,001–4,000

☐More than $4,000 보다 많음

☐ 밝히지 않음 Decline to answer

*인종 (해당항목 모두 체크)****Race*** *(check all that apply)*

☐ 아메리칸 인디언 또는 알래스카 원주민
American Indian or Alaska Native

☐ 아시안 Asian

☐ 흑인 또는 아프리카계 미국인 Black or African American

☐ 하와이 원주민 Native Hawaiian

☐ 백인 White

☐ 그외 태평양 섬 원주민 Other Pacific Islander

☐ 밝히지 않음 Unreported/Refused to report

당신을 포함하여 ***몇명이 같이 거주*** *합니까?*

Including yourself, ***how many people live in your household?***

_____ 명 people

가정에서 ***주로 사용하는 언어****는 무엇입니까***?**

What is your ***primary language spoken at home?***

_____

선호하는 약국 PREFERRED PHARMACY

약국 이름 Pharmacy Name: _____ 전화 Phone: (_____)_____

주소 Address: _____

비상 연락처 EMERGENCY CONTACT

이름 Name: _____

(성 Last) (이름 First)

본인과의 관계 Relationship: _____ 전화 Phone: (_____)_____

해당사항 모두 체크 Please check all that apply: ☐ 부모 /환자의 보호자 Parent/guardian of patient ☐ 환자의 건강정보 공개 Disclose patient health information

그외 연락처(들)ADDITIONAL CONTACT(S)

이름 Name: _____

(성 Last) (이름 First)

관계 Relationship: _____ 전화 Phone: (_____)_____

해당사항 모두 체크 Please check all that apply: ☐ 부모 /환자의 보호자 Parent/guardian of patient ☐ 환자의 건강정보 공개 Disclose patient health information

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이름 Name: _____

(성 Last) (이름 First)

본인과의 관계 Relationship: _____ 전화 Phone: (_____)_____

해당사항 모두 체크 Please check all that apply: ☐ 부모 /환자의 보호자 Parent/guardian of patient ☐ 환자의 건강정보 공개 Disclose patient health information

의료보험 정보 INSURANCE INFORMATION

보험이 있습니까? ☐ 예 ☐ 아니요
Do you have insurance? Yes No

일차 보험: _____
Primary insurance:

정책번호. (Policy #): _____

그룹번호. (Group #): _____

전화 (Phone): (_____)_____

Type: ☐ EPO ☐ HMO ☐ PPO ☐ POS ☐ DMO ☐ Other

이차 보험(있을 경우)**:** _____
Secondary insurance(If applicable)**:**

정책번호. (Policy #): _____

그룹번호. (Group #): _____

전화 (Phone): (_____)_____

Type: ☐ EPO ☐ HMO ☐ PPO ☐ POS ☐ DMO ☐ Other

ASSIGNMENT OF BENEFITS

I hereby assign all medical and surgical benefits, including major medical benefits to which I entitled such as Medicare, private insurance, and any other health plan, to CPACS Cosmo Health Center/Dental Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as the original.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the assignee to release all information necessary to secure payment.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby give my consent for CPACS Cosmo Health Center (Cosmo) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (CPACS Cosmo Health Center Notice of Privacy Practices provides a more complete description of such uses and disclosures).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Cosmo reserves the right to revise its Notice of Privacy Practices prior to signing this consent. Cosmo reserves the right to revise its Notice of Privacy practices at any time. A revised Notice of Privacy Practices may be obtained by a written request to:

Administrative Office	Service Site
Center for Pan Asian Community Services	**CPACS Cosmo Health Center**
3150 Shallowford Rd NE	6185 Buford Hwy Building A1&G
Atlanta, GA 30341	Norcross, GA 30071

With this consent, Cosmo may call my home or alternate location and leave a message in reference to any items that assist the health center in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others. With this consent, Cosmo may mail to my home or other alternate locations any items that assist the practice in carrying out TPO, such as letters and patient statements.

With this consent, Cosmo may send mails to my home or other alternative locations utilizing *eClinicalWorks*, our electronic medical records system which assists the practice in carrying out TPO.

I understand that my PHI is protected under the federal regulations governing the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164; as well as under 42 CFR Part 2; and cannot be disclosed without my written consent unless otherwise provided for in federal regulations.

I have the right to request that Cosmo restrict how it uses or disclose my PHI to carry out TPO. However, the health center 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 Cosmo 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, Cosmo may decline to provide treatment to me.

I understand that I can receive Title X Family Planning services confidentially and voluntarily regardless of my ability to pay.

Restrictions on disclosure (OPTIONAL): _____

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian

Prescription History & ePrescribing Consent Form

ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.
- **Fill status notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at CPACS Cosmo Health Center as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.***

ePrescribe Program Consent

By signing this consent form you are agreeing that your provider at CPACS Cosmo Health Center may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to CPACS Cosmo Health Center to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name	Patient DOB
Signature of patient or guardian	Today's Date
Relationship to Patient	

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize: _____
_____
_____

To release copies of medical records compiled during office visits and/or hospital admissions.

Patient Name: _____ **DOB: _____**

Release medical records to: CPACS Cosmo Health Center:

Medical: 6185 Buford Hwy, Bldg G
Norcross, GA 30071
P)770-446-0929 Fax)770-446-6977

Dental: 6185 Buford Hwy, Bldg A1
Norcross, GA 30071
P) 770-674-7980 Fax) 470-545-2277

The type and amount of information to be used or disclosed is as follows:

- ☐ Problem list
- ☐ Medication list
- ☐ List of allergies
- ☐ Immunization records
- ☐ Most recent history and physicals
- ☐ Most recent discharge summary
- ☐ Laboratory results
- ☐ X-Ray and imaging reports
- ☐ Consultation reports
- ☐ Entire record
- ☐ Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral health or mental health services and treatment for alcohol and drug abuse. I understand that my health information is protected under the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records, 42 CFR Part 2; and that re-disclosure is prohibited under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the HIPAA Privacy Law.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at the end of the pending of my claim or lawsuit.
I understand that authorizing the disclosure of this health information is voluntary; I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative *Date*

cpacs.cosmo health center
Federally Qualified Health Center

환자 건강 설문지
Patient Health Questionnaire (Korean)

12세 미만 아동은 작성하지 마십시오
Skip the form for children under 12 years of age

이름 Name: _____ **생년월일 DOB:** _____ **날짜 Date:** _____

	지난 2 주일 동안 당신의 상태를 아래 문장을 읽고 대답해 주세요. (동그라미로 답을 표시해 주십시오.) Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use " ✓ " to indicate your answer.)	**전혀 안그랬다** Not at all	**며칠동안 그랬다** Several days	**7 일이상 그랬다** More than half the days	**거의매일 그랬다** Nearly every day	**답할 수 없음** Decline to Specify
1	**일 또는 여가 활동을 하는데 흥미나 즐거움을 느끼지 못함** Little interest or pleasure in doing things	☐	☐	☐	☐	☐
2	**기분이 가라앉거나, 우울하거나, 희망이 없음** Feeling down, depressed, or hopeless	☐	☐	☐	☐	☐

위의 질문 1 과 2 에 **"전혀 안 그랬다"** 혹은 **"답할 수 없음"**이라고 답하셨다면 STOP 여기에서 멈추십시오.
If you answered **"Not at all"** or **"Declined to specify"** to BOTH **1** and **2**, STOP STOP HERE.

지난 2 주일 동안 당신의 상태를 아래 문장을 읽고 대답해 주세요. (동그라미로 답을 표시해 주십시오.) Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use " ✓ " to indicate your answer.)	**전혀 안그랬다** Not at all	**며칠동안 그랬다** Several days	**7 일이상 그랬다** More than half the days	**거의매일 그랬다** Nearly every day
3. 잠이들거나 계속 잠을자는 것이어려움, 또는 잠을 너무 많이 잠 Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. 피곤하다고 느끼거나 기운이 거의 없음 Feeling tired or having little energy	☐	☐	☐	☐
5. 입맛이 없거나 과식을 함 Poor appetite or overeating	☐	☐	☐	☐
6. 자신을 부정적으로 봄--혹은 자신이 실패자라고 느끼거나 자신 또는 가족을 실망시킴 Feeling bad about yourself--or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. 신문을 읽거나 텔레비전 보는것과 같은일에 집중하는 것이 어려움 Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. 다른 사람들이 주목할 정도로 동작이나 말이 너무 느려짐, 또는 반대로 너무 안절부절 못하거나 들떠 있어서 평상시보다 많이 움직임 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	☐	☐	☐	☐
9. 자신이 죽는것이 더 낫다고 생각하거나 어떤 식으로든 자신을 해칠 것이라고 생각함 Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
병원 관계자 기재란 **FOR OFFICE CODING**	☐	+_____	+_____	+_____
		총점 **TOTAL SCORE**		_____

만일 당신이 위의 문장 중 하나 이상 "예" 라고 응답하셨으면, 이러한 문제들로 인해서 직장생활에서나 가정일에서 또는 다른 사람과 어울릴 때 얼마나 어려움을 겪었습니까? (동그라미로 답을 표시해 주십시오.)
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

전혀 어렵지 않았다 **Not difficult at all**	**약간 어려웠다** **Somewhat difficult**	**많이 어려웠다** **Very difficult**	**매우 많이 어려웠다** **Extremely difficult**