Consent for Treatment

I, ______________________________ am authorized and hereby give consent for the medical staff of
(Patient/Guardian)
the WeCareTLC Clinic to examine and render care to ______________________________.
(Name of Patient / Self)
This consent shall remain in effect until revoked in writing.

Your privacy is of utmost concern to us at WeCareTLC Clinic and we strictly adhere to HIPAA regulations. These regulations **do allow us** to call you at a phone number provided by you for specific purposes. We can call you to remind you of upcoming appointments and to leave either a voice mail message or a message with the person who answers the phone asking you to call us back. **We do not leave Personal Health Information (PHI) unless authorized by you.**

Please read the following statements and indicate your acknowledgement and/or authorization for each:

_____ I acknowledge that I have received/read a copy of the center's HIPAA information.

_____ I authorize the staff of the WeCareTLC Clinic to leave detailed messages **only via voice mail** on the phone number provided. These messages may contain Personal Health Information (PHI) such as the results of tests.

_____ I authorize the staff of the WeCareTLC Clinic to leave detailed messages containing PHI **to any person** answering the below phone number/s.

Authorized Phone Number/s ________________________ or ____________________________.

Please indicate the people you authorize to either pick up prescriptions and/or refills or other medical supplies for you AND the people you authorize with whom the staff (including our providers) may discuss your medical condition/s. This will include PHI. **Please circle Yes or No for each person.**

Authorized Person/s:	**Relationship:**	**Rx PickUp**	**Discuss PHI**
________________________	_____________	Yes No	Yes No
________________________	_____________	Yes No	Yes No
________________________	_____________	Yes No	Yes No
________________________	_____________	Yes No	Yes No

Signature: ________________________________ Date: ___________________

Witness: ________________________________ Date: ___________________

WeCareTLC, LLC

Confidential Health History Date: ______________

Name: ______________________________ Age: _____ Date of Birth: ______________

Marital Status: S ( ) M ( ) W ( ) D ( ) **Date of Last Physical Exam:** ____________

SYMPTOMS: Check (X) symptoms you currently have or have had in the past year.

General		Gastro		EENT		Men Only	
Chills		Poor Appetite		Bleeding Gums		Breast Lump	
Depression		Bloating		Blurred Vision		Erection Difficulties	
Dizziness		Bowel Changes		Crossed Eyes		Lump in Testicles	
Fainting		Constipation		Difficult Swallowing		Penis Discharge	
Fever		Diarrhea		Double Vision		Sore on Penis	
Forgetfulness		Excessive Hunger		Earache		Other:	
Headache		Excessive Thirst		Ear Discharge		**Women Only**	
Loss of Sleep		Gas		Hay Fever		Abnormal Pap	
Loss of Weight		Hemorrhoids		Hoarseness		Bleeding between Periods	
Nervousness		Indigestion		Loss of Hearing		Breast Lump	
Numbness		Nausea		Nosebleeds		Extreme Menstrual Pain	
Sweats		Rectal Bleeding		Persistent Cough		Hot Flashes	
		Stomach Pain		Ringing in Ears		Nipple Discharge	
		Vomiting		Sinus Problems		Painful Intercourse	
		Vomiting Blood		Vision Flashes		Other:	
						Date of Last Menstrual Period	
Pain, Weakness, Numbness in:						Date of Last Pap Smear	
Arms		Hips				Date of Last Mammogram	
Legs		Neck				Are you Pregnant?	
Feet		Shoulders				Number of Children	
Hands		Back					
G/U		**Cardiovascular**				**Skin**	
Blood in Urine		Chest Pain				Bruise Easily	
Frequent Urination		High Blood Pressure				Hives	
No Bladder Control		Irregular Heartbeat				Itching	
Painful Urination		Low Blood Pressure				Change in Moles	
		Poor Circulation				Rash	
		Rapid Heartbeat				Scars	
		Swelling Ankles				Unhealing Sore	

CONDITIONS: Check (X) conditions you have had in the past:

AIDS		Chemical Dependency		High Cholesterol		Prostate Problem	
Alcoholism		Chicken Pox		HIV-Positive		Psychiatric Care	
Anemia		Diabetes		Kidney Disease		Rheumatic Fever	
Anorexia		Emphysema		Liver Disease		Scarlet Fever	
Appendicitis		Epilepsy		Measles		Stroke	
Arthritis		Glaucoma		Migraine Headaches		Suicide Attempt	
Asthma		Goiter		Miscarriage		Thyroid Problem	
Bleeding Disorder		Gonorrhea		Mononucleosis		Tonsillitis	
Breast Lump		Gout		Multiple Sclerosis		Tuberculosis	
Bronchitis		Heart Disease		Mumps		Typhoid Fever	
Bulimia		Hepatitis		Pacemaker		Ulcers	
Cancer		Hernia		Pneumonia		Vaginal Infections	
Cataracts		Herpes		Polio		Venereal Disease	

MEDICATIONS: Include all prescription and over the counter medications	ALLERGIES:

FAMILY HISTORY

Relation	Age	Living/Deceased	Cause of Death	Check (X) if your blood relatives had the following:		
					Disease	Relationship to You:
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
Sisters					Heart Disease, Stroke	
					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization

Have you ever had a blood transfusion? ___________ If so, give approximate date: ___________

Serious Illness / Injury	Date	Outcome	Check Any Substances you use and how much		
			Caffeine		
			Tobacco		
			Drugs		
			Alcohol		
			Other		

Pharmacy Name: ________________________ **Location:** ______________ **Phone Number:** ______________________

Please share any other medical history that was not covered above:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: ____ **Date:** __________________________

Reviewed by: ____ **Date:** __________________________