Clínica Médica Hispana
Medical Corp.

14906 Paramount Boulevard
Paramount, California 90723

Main phone number:
(562) 630 – 1991. Use this phone number to schedule appointments, answer your general questions, and connect you with team members.

Office hours:
Mondays 9am – 6pm, and
Tuesdays – Saturdays 9am – 7pm.

Web address:
www.cmhmc.com
You can also contact us by secure messaging via your dedicated patient portal through this website.

Welcome to your Patient Centered Medical Home

Thank you for choosing us to be part of your healthcare team. We look forward to working with you to make sure you receive the care you need and keep you healthy and happy.

Our practice provides personalized primary care, preventative and health maintenance care and access to various specialty services. We also fully manage care for our patients with disabilities, chronic illness, and other complex medical conditions.

We hope that the information provided on this guide will answer many of the questions you may have about our practice

Our Model of Care: A Medical Home

Clinica Medica Hispana Medical Corp. is committed to providing you with the quality care you need, when you need it most. In a medical home, you are part of a team along with doctors, nurses, and medical assistants – that designs a plan to keep you in good health.

As a member of this team, you may seek health advice by phone during regular office hours from another member of your team. We strongly encourage you to schedule all your appointments in advance, but understand that unexpected situations do arise. If you come without an appointment, a medical assistant from our team will assess your needs. If you need to be seen by a provider, we will make every effort to make an appointment for that same day.

Our Mission

The mission of Clinica Medica Hispana Medical Corp. is to improve the health and well-being of the communities surrounding Paramount, California by providing quality, comprehensive, coordinated care.

What is Family Medicine?

The specialty of family medicine is centered on lasting, caring relationships with patients and their families. Family physicians have received clinical training to take care of children as well as adults to provide continuing and comprehensive health care to patients regardless of age, sex, ethnicity, or disease.

What Will Your Medical Home at Clinica Medica Hispana Do For You?

In a medical home, you join a team. The team consists of you (the team leader) and the health care workers assigned to it.
Working with you, we will:

- Help you choose a primary care provider,
- Schedule appointments that fit your schedule,
- Coordinate your care,
- Provide advice and/or care when you need it during or after office hours,
- Work with you to create an action plan for your health,
- Use best practice medicine to consistently deliver your care,
- Support you in caring for yourself.

"At Clinica Medica Hispana, I feel my health is in great hands of knowledgeable doctors and staff"

— Mrs. E. Valles

What is your role in your Medical Home?

- Inform the team of medical care scheduled or received out side of our office,
- Stick with the action plan the team creates together for your health,
- Take responsibility for making healthy life style changes every day.

Appointments

New patients will be asked if they have been referred to a specific physician at Clinica Medica Hispana. If they specify a particular physician every effort should be made to accommodate them in the doctor's schedule. If they do not have a specific physician, we can provide you a pamphlet with their medical background to allow the patient a better understanding of which physician meets their medical needs or personal preferences.

If you would like to speak to a clinician about your symptoms, please call (562) 630 – 1991 and ask for him/her directly.

If you have an emergency illness or symptoms that require immediate, urgent attention, call 911. If you need an appointment for illness or a symptom, call (562) 630 -1991 and let the receptionist know.

If you need a check-up, follow up visit, or annual visit please call the main number (562) 630 – 1991 and speak with the front office staff.

Patients who are more than 15 minutes late may be required to reschedule their appointments.

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During your Appointment

Please bring your insurance card.

Please bring a list of current prescription and non-prescription medications, vitamins and supplements. You can also bring a bag with all current medications you are taking if you prefer rather than a written list.

Please provide any records or logs of self-care health management. For example, blood pressure or sugar level management. Provide a good description of the problem, how long you have had it and how it affects you. Provide a list of questions you would like to discuss with your provider.

Provide a list of other health care providers you have visited.

If you need interpretation during your appointment please feel free to request it.

After Hours Care

If you would like to speak to a clinician to help you decide how to treat an illness after hours or to help you decided whether to go to the emergency room, call (562) 630 – 1991. This is a special after-hours service we offer and they will have access to contact the clinician directly.

If you receive care at an emergency room or urgent care center, please let us know by calling (562) 630 -1991 within 48 hours so we can assist with follow up care as needed.

Special accommodations

The Practice is accessible by wheelchair. People with limited sight should bring a companion to ensure clear communication. People with limited hearing can request deaf interpreter services free of charge by their health plan.

Please let us know if you prefer to receive your care in Spanish.

Laboratory & Diagnostic Tests

If your provider orders laboratory and/or diagnostic tests you will be referred to the facility preferred by your medical insurance plan.

A member of your team will call you to let you know that your test results are in and to follow up with the provider.

All laboratory and diagnostic results will be available on your patient portal after the physician reviews the results.

If you have not received your results within one week, please call our office.

Payment options

We participate in most insurance plans, including Medicare. Be sure to check with us to confirm that we accept your insurance before making an appointment.

Please be prepared to pay your co-pay and/or patient balance at the time of service. We accept cash and personal checks.
We are happy to answer questions, discuss payments or your bill anytime by calling (562) 630 – 1991.

Prescriptions

For refills of prescriptions please contact your pharmacy.

If you need a written prescription, please call (562) 630 -1991 and discuss directly with your provider.

Please allow 48 hours for us to refill your prescriptions. We will contact you only if there is a problem or we have a question about your prescription refill request.

Please remember that refills can only be given to patients who have been seen within the past 3 months. If you have not been seen for more than 3 months, you will need to schedule an appointment.

If you have questions about a new prescription or about discontinuing medications, please call your clinician.

After hours, urgent refills will be handled by the on call physician.

"The doctors at Clinica Medica Hispana make me feel comfortable and well taken care of."
—Mr. H. Montes de Oca

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We respect your time and would like to make your visit as efficient as possible.

Please arrive 15 minutes before your scheduled appointment time.

To avoid delays when you arrive, *please complete the enclosed forms in advance via mail, fax 562-630-0145 or bring them with you to our office.*

Thank you,
Clinica Medica Hispana Medical Corp. Management

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Medical Corp.

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DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

(California Civil Code Section 2410-2444)

WARNING TO PERSON EXECUTING THIS DOCUMENT

1. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

By this document I intent to create a durable power of attorney by appointing the person designated below to make health care decisions for me as allowed by Sections 2410 to 2444, inclusive, of this California Civil Code. This power of attorney shall not affect by my subsequent incapacity. I hereby revoke any prior durable power of attorney for health care. I am a California resident who is at least 18 years old, of sound mind, and acting of my own free will.

2. APPOINTMENT OF HEALTH CARE AGENT

Fill in below the name, address and telephone number of the person you wish to make health care decisions for you if you become incapacitated. You should make sure that this person agrees to accept this responsibility. The following may not serve as your agent: (1) your treating health care provider; (2) an operator of a community care facility or residential care facility for the elderly; or an employee of your treating health care provider, a community care facility, or residential care facility for the elderly, unless employee is related to you by blood, marriage or adoption. If you are conservator under the Lanterman-Petris-Short Act (the governing involuntary commitment to a mental health facility) and wish to appoint your conservator as your agent, you need not consult a lawyer, who must sign and attach a special declaration for this document to be valid.

I, _____, hereby appoint:

Name: _____

Address: _____City: _____ State: _____

Telephone: (_____)_____

_____ _____
(Signature) (Date)

ALL MEMBERS 18 YEARS AND OVER MUST BE OFFERED AN ADVANCE DIRECTIVE

CLINICA MEDICA HISPANA MEDICAL CORP.
14906 PARAMOUNT BLVD.
PARAMOUNT, CALIFORNIA 90723
(562) 630 – 1991
FAX: (562) 630 – 0145

Patient Name:_____DOB:_____

I_____(printed name of patient or personal representative) whose signature appears below, authorize Clinica Medica Hispana Medical Corp., and its affiliated providers to view my external prescription history.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

My signature certifies that I read and understood the scope of my consent and that I authorize the access.

_____ _____

Patient's signature or personal representative **Date**

_____ _____

Witness **Date**

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Marital Status: Married Single Divorced Widow Ethnicity: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____Phone: _____

E-mail address: _____ Cell Phone: _____

Employer: _____ Address: _____ Phone: _____

Occupation: _____ Social Security: _____-_____-_____ Driver's License: _____

IN CASE OF EMERGENCY NOTIFY:

Name: _____ Relationship: _____Phone:_____

NEAREST RELATIVE/FRIEND NOT LIVING WITH YOU:

Name: _____ Relationship: _____Phone:_____

Spouse: _____ Or Legal Guardian: _____

Employer: _____ Address: _____ Phone: _____

Occupation: _____ Social Security: _____-_____-_____ Driver's License: _____

IF A MINOR, NAME OF LEGAL GUARDIAN: _____

I HEREBY GIVE PERMISSION FOR THE ABOVE NAMED PATIENT TO BE TREATED BY CLINICA MEDICA HISPANA MEDICAL CORP. IN SIGNING THIS, I AM STATING THAT I AM THE LEGAL GUARDIAN, THEREBY HAVING THE AUTHORITY TO GIVE SUCH PERMISSION FOR TREATMENT AS MAY BE NECESSARY TO THIS MINOR.

AGREEMENT AND CONSENT FOR TREATMENT
CLINICA MEDICA HISPANA MEDICAL CORP.

MEDICAL AND SURGICAL: I hereby consent to any medical or surgical procedure which my physician(s) may consider necessary or advisable in the treatment of my medical condition(s).

Date: _____ Signed: _____ Relationship: _____

Name of Insurance Co: _____ Group#: _____ Id#: _____

Medical#: _____ Medicare: _____ Coverage: _____

IS THIS VISIT PAYABLE BY YOUR INSURANCE? YES NO

ASSIGNMENT OF BENEFITS
CLINICA MEDICA HISPANA MEDICAL CORP.

I hereby assign to Clinica Medica Hispana Medical Corp. all benefits provided by my insurance policy for medical and/or surgical care. A photostatic copy of this agreement is as binding as the original.

Date: _____ Insured's Signature: _____

Date: _____ Patient's Signature: _____

CLINICA MEDICA HISPANA MEDICAL CORP.

Date: _____

Name: _____ **Birthdate**: _____ **Age**: _____
First Middle Last Month/Day/Year

Address: _____
Number Street Apt. # City Zip Code

Phone: (_____) _____ Cell: (_____) _____**Gender:** __M____F_____

In what language would you like to receive information from Clinica Medica Hispana: SPANISH ENGLISH

Ethnicity: ☐AMERICAN INDIAN ☐ASIAN ☐ BLACK ☐ FILIPINO ☐ HISPANIC ☐WHITE ☐ PACIFIC ISLANDER ☐ MIDDLE EASTERN

Marital Status: (Circle one) **SINGLE MARRIED WIDOWED DIVORCED LIVING TOGETHER**

Have you been to the Emergency Room Department or been hospitalized since our last visit? ☐NO ☐ YES Give **MR** Release

Did you do self-referral or see other clinicians since our last visit? ☐NO ☐ YES Give **MR** Release MARK TRANSITION OF CARE

If patient is under 18 yrs old who is accompanying child: Mother Father Foster Parent Other: _____

Insurance: **Cash Patient HMO PPO Medical Medicare CDP Family Pact Presumptive Eligibility**

Reason for todays Visit?

E-mail: _____

☐ Consultation/ Illness

☐ Results of:(Circle one) **Blood work Pap Smear X-Rays Mammogram Ultrasound**

☐ Physical Exam ☐General ☐ Sports ☐ School ☐ Work ☐ Immigration (Residency)

☐ Blood Work only

☐ Pregnancy Test: Last Menstrual Period _____

☐ Mammogram only ☐ Pap Smear only ☐Mammogram & Pap Smear

☐ Pregnancy Visit ☐ Diabetes Test ☐ Blood Work ☐ Results

☐ Postpartum Visit (6 wks) ☐ Staple Removal

☐ Immunization (Shots)

☐ Family Planning

☐ Birth Control Pill ☐ Depo Shot ☐ Condoms ☐ IUD ☐ BTL ☐ Morning After Pill ☐ Patch ☐ Vasectomy

☐ OTHER: ☐ TB Test ☐ TB Check ☐ WIC paper

In case of emergency who can we contact?

Name: _____

Telephone: _____

Relationship: _____

☐ AA ☐EG ☐HP ☐AH ☐IG ☐IA ☐KL ☐SP ☐AC ☐ NA ☐ VA ☐ _____