DOCTOR'S LIEN
AND RELEASE OF MEDICAL DOCUMENTS

SOUTHERN CALIFORNIA
INJURY TREATMENT CENTER
15857 POMONA RINCON ROAD
CHINO HILLS, CA 91709
PH: 844-787-3286
FX: 909-591-0538

Attorney Name (律师) :_____
Address (地址): _____
_____
_____

TO ATTORNEY ON THE CASE OF: _____
DATE OF INJURY (受伤的日期) : _____

This is a contract and a legal binding document which binds the attorney and patient to ensure that the doctor is paid for his services once the case is settled or a verdict is received. PLEASE SIGN AND FAX BACK TO (909) 591-0538. 这是一份合同和具有法律约束力的文件，对律师和患者具有约束力，以确保在案件和解或判决确定后，要确保支付医生的服务费用。请签名并传真（909）591-0538。

I do hereby authorize **Southern California Injury Treatment Center**, to furnish you, my attorney, with a full report of my examination, diagnosis, treatment, prognosis, etc., in regards to the accident dated 我谨在此授权 **South California Injury Treatment Center**, 自事故发生期向我的律师提供事故后我的身体检查，诊断，治疗，预后等方面的完整报告。

I hereby authorize and direct you, as my attorney for the personal injury case, to pay directly to **Southern California Injury Treatment Center** such sums as may be due and owing him/her for medical services rendered me both by reason of this accident and by reason of any other bills that are due his/her office and to withhold such sums from any settlement, or verdict as may be necessary to adequately protect such lien. 我在此授权并指示您,作为我的人身伤害案件的律师，直接付款给 **South California Injury Treatment Center**。无论是由于这次事故还是由于其他原因所产生的医疗服务欠款都应该付清。这笔款项要从任何和解或判决中扣留作为充分保护此类留置权的需要。

This is a third party lien given by the undersigned client to the benefit of the services for the above mentioned case. Your client instructs you not to revise this agreement and sign it immediately. If you fail to sign this document within the specified time, you will be in direct conflict with client instructions. 这是签名客户所提供给上述服务中受益的第三方留置权。 您的客户指示您不要修改此协议并立即签署。 如果您未能在指定时间内签署此协议，您将与客户的指示直接有不相符合

_____
PATIENT INITIALS (患者首字母缩写)

I understand that I am directly responsible for the said medicals and for all medical bills incurred for services regardless of the outcome of the case. **I understand, that if the doctor is not successful after due diligence in contacting the attorney or if the attorney refuses to cooperate, that this lien will be void and I am personally responsible for the outstanding medical bills**. 我了解，无论案件结果如何，我均应对上述医疗服务和所产生的所有医疗费用直接负责。 **我了解，如果医生在尽职努力后未能成功联系到律师，或者如果律师拒绝合作，则该留置权将作废，我个人应对未付的医疗费用负责**。

_____ _____
PATIENT SIGNATURE (签名) DATE (日期)

_____
PRINT NAME (正楷姓名)

The undersigned being the attorney for the injured above mentioned party hereby agrees to observe all the terms of this agreement between the doctor and the client and agrees to withhold such sums for any settlement, judgment or verdict as may be necessary to protect said doctor's lien. If dispute arises from this agreement and if the doctor prevails, the attorney or patient, as ordered by court, will be responsible to pay for **actual attorney fees and costs**. 作为上述受害方的律师，签字人在此同意遵守医生与委托人之间在本协议中的所有条款，并同意为保护该医生的留置权而扣留一些款项，用以支付进行任何必要的和解，判决或裁决。如果本协议引起纠纷，并且如果医生胜诉，则律师或患者将按照法庭的命令，负责支付**实际的律师费和成本花费**。

A COPY OR A FAXED COPY OF THIS DOCUMENT IS A VALID AS THE ORIGINAL
(本文档的副本或传真副本作为原始文档有效)

_____ _____
ATTORNEY SIGNATURE (律师签名) DATE (日期)

SOUTHERN CALIFORNIA INJURY TREATMENT CENTER
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AUTHORIZATION OF BENEFITS (福利授权)

I (我), _____ assign any and all rights and benefits under my policy to the following doctor or facility (将本人保单项下的任何和所有权力与利益转让给以下医生或机构) :

Southern California Injury Treatment Center 15857 Pomona Rincon Road, Chino Hills, CA 91709

I ask that any and all checks due to me under my policy to be made out to the doctor or facility mentioned above. If my policy has a prohibition of assignment clause and does not allow assignment of benefits under my policy, then I instruct my insurance company to make the check payable to me but mail the check to the address mentioned above. Any failure to comply with this assignment will be violation of Insurance Code Section 790.03 and Insurance Regulation and will be considered a violation of my rights under the policy. (我要求根据我的保单，应付给我的用于治疗的任何和所有支票都应支付给上述医生或机构。如果我的保单有禁止转让条款，并且不允许在我的保单下分配福利，那么我指示我的保险公司将支票支付给我，但将支票邮寄到上述地址。任何不遵守此任务的行为都将违反《保险法典》第 790.03 节和保险条例，并将被视为侵犯我在保单下的权利.)

Authorization to Release Information (授权发布信息)

I hereby authorize **Southern California Injury Treatment Center** to: (1) release any information necessary to insurance carriers regarding my illness and treatments, (2) process insurance claims generated in the course of examination or treatment, and (3) allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing. 我特此授权 **Southern California Injury Treatment Center**: (1) 向保险公司发布有关我的疾病和治疗的任何必要信息, (2) 处理在检查或治疗过程中生成的保险索赔, (3) 允许使用我签名的复印件来处理终身保险索赔。此命令将一直有效，直到我以书面形式撤销.)

I have requested medical services from **Southern California Injury Treatment Center** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. (我已代表本人和/或我的受抚养人向 **Southern California Injury Treatment Center** 申请医疗服务，并了解通过提出此请求，我应对在授权治疗过程中发生的任何费用承担全部财务责任.)

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid and original. (我理解，费用在提供服务之日到期并支付，并同意在提交适当声明后立即全额支付所有此类费用。此任务的影印本将被视为有效和原始.)

The payment under the policy should be mailed to my provider at once and no unnecessary delays are acceptable. (根据该政策付款应一次邮寄到我的医疗机构，并且不应有不必要的延误.)

Date (日期): _____

Print Name (正楷名字) : _____

Signature (签名) : _____

Thank you for choosing Southern California Injury Treatment Center. Please take the next few minutes to complete the following paperwork. Answer each question with as much detail as possible. If you need more room, please use the back of this paper. (谢谢您选择 Southern California Injury Treatment Center。请填写以下资料，用尽可能多的细节回答每个问题。如果您需要更多空间，请使用背面的空间。

PATIENT DEMOGRAPHICS (病人信息)

Name (名字) : _____ Date(日期) : _____

Social Security Number (社会保险号): _____-_____-_____

Driver's License Number (驾照的号码) : _____

Date of birth (出生日期) : _____

E-mail address (电子邮件的地址) : _____

Street Address (街道地址) : _____

City (城市): _____

State (州) : _____ Zip Code (邮政编码) : _____

Home Phone (家庭电话) : _____

Cell Phone (手机电话): _____

Occupation (职业) : _____

Business Phone (工作电话) : _____

Sex (Circle one) 性别（圈出）: Male (男) Female (女)

Marital Status (Circle) 婚姻状况（圈出）:

Single (单身) Married (结婚) Domestic Partner(伴侣) Divorced (离婚) Separated (分居) Widowed (丧偶)

Spouse's Name (配偶姓名): _____

# of Children (几个小孩): _____ Ages (小孩的年龄) : _____

Emergency Contact Name (紧急联系人姓名) : _____

Relationship (关系) : _____

Contact Phone (紧急联系人电话号码) : _____

How did you hear about us? (Please circle) 你是怎么知道我们的?(请圈出)

Attorney (律师) Doctor Office (医生诊所) Other (其他): _____

Referred by (推荐者): _____ City (城市) : _____

(NAME 名字)

PLEASE PROVIDE ALL PERTINENT INFORMATION REGARDING YOUR CAR AND/OR INSURANCE COVERAGE. IF YOU HAVE SECONDARY INSURANCE PLEASE GIVE INFO FOR BOTH PARTIES.

(请提供有关您的汽车和保险范围的所有相关信息。如果您有二级保险，请提供双方的信息.)

INSURANCE INFORMATION
(保险信息)

AUTO INSURANCE NAME (汽车保险公司名称) :
_____
POLICY NUMBER (保单编号):
_____
ADDRESS (地址) : _____
_____
ADJUSTER NAME (理赔员姓名) : _____
PH 电话号码 : _____
CLAIM NUMBER (索赔编号) : _____
POLICY LIMIT (索赔限额) : _____

OTHER PARTY INSURANCE INFORMATION
(别的保险信息)

AUTO INSURANCE NAME (汽车保险公司名称) :
_____
POLICY NUMBER (保单编号):
_____
ADDRESS (地址) : _____
_____
ADJUSTER NAME (理赔员姓名) : _____
PH 电话号码 : _____
CLAIM NUMBER (索赔编号) : _____
POLICY LIMIT (索赔限额) : _____

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MEDICAL INFORMATION RELEASE (公开医疗信息)

I hereby authorize (name and address of healthcare provider)
我特此授权（医疗保险者的姓名和地址）

_____

_____

to release/disclose my personal health information (PHI) for purposes of payment, health care operations and treatment. The information and records, which may be released to any medical psychiatric, psychological, psychotherapy, alcohol and/or drug abuse records and/or information, which he/she may have regarding. 可以发布/披露我的个人健康信息（PH）,用于付款、健保和治疗。这些信息和记录，可以公开给任何治疗精神病、神经心理治疗、酒精和/或药物滥用记录和/或一些相关的信息。

_____, _____
(Patient Name) （患者姓名） (Date of birth) (出生日期)

Examples of these types of uses and disclosures include ：这些信息的公开和使用包括以下的用途

PAYMENT (付款) : We use and disclose your PHI in order to process claims and seek reimbursement for your health expenses covered by an insurer.我们使用和公开您的医疗信息来处理索赔，并寻求保险公司支付您的健康费用。

TREATMENT (治疗) : We may disclose your PHI to assist in your health care (doctors, pharmacy and others) in your diagnosis and treatment. 我们可能会公开您的医疗信息，以协助您的医疗保健提供者（医生、药房、和其他机构）对您进行诊断和治疗。

OTHER PERMITTED OR REQUIRED DISCLOSURES OF YOUR PHI ： （其他允许或被要求公开您的医疗信息的情况有：）

AS REQUIRED BY LAW (根据法律要求) : We may disclose your PHI when required to do so by law (i.e., Workers' Compensation) 当法律要求时我们可能会披露您的医疗信息（比如：劳工补偿法律。）

PUBLIC HEALTH ACTIVITIES (公共卫生活动): We may disclose PHI to public health agencies foreasons such as preventing or controlling disease, medical injury, or disability, and/or enable product recalls, repairs or replacements. 我们可能会出于预防或控制疾病、医疗伤害或残疾和/使用产品召回、维修、或更换等原因向公共卫生机构提供您的医疗信息。

Initial (名字首字母缩写) ：_____

Signature (签名) : _____ Date (日期) ：_____

Print Name (正楷名字) : _____

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PHYSICIAN-PATIENT ARBITRATION AGREEMENT（医患仲裁协议）

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.
声明一**: 仲裁协议**:据了解，任何医疗事故纠纷，即根据本合同提供的任何医疗服务是否不必要或未经授权，或不当、疏忽或无行为能力，均由加州法律规定的提交仲裁决定，而不是通过诉讼或诉诸法庭程序，除非加州法律规定司法审查或仲裁程序。本合同的双方通过签订本合同，放弃宪法权利，在法院由陪审团裁决任何此类争议，而是接受仲裁的使用.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.
声明二: **所有索赔都必须进行仲裁**。双方的意图是，本协议对所有可能引起索赔或与医生提供的治疗或服务有关的各方具有约束力，包括患者的配偶或继承人以及任何子女（无论出生或未出生），在事件发生时引起的任何索赔。 对于怀孕的母亲，此处的"患者"一词应既指母亲又指母亲的预期子女。

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (part arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each part to the arbitration shall pay such part's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a part for such party's immunity shall supplement, not supplant, any other applicable statutory or common law.
声明三:**程序和适用法律**：仲裁要求必须以书面形式传达给各方。各方应在三十天内选择一名仲裁员（部分仲裁员），第三名仲裁员（中立仲裁员）应由双方当事人要求中立仲裁员的三十天内由双方指定的仲裁员选出。仲裁的每一部分应按比例支付中立仲裁员的费用和费用，以及中立仲裁员发生的或批准的仲裁的其他费用，不包括律师费或证人费，或该部分为该方的豁免而发生的其他费用应补充而不是取代任何其他适用的法定或普通法。

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.
任何一方均有权在向中立仲裁员提出书面请求时分别仲裁责任和损害赔偿问题。

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. 当事人同意对任何本应是法院诉讼中适当的另一方的人或实体进行本次仲裁的干预和合并，并且在进行干预和合并后，针对该其他人或实体的任何现有法院诉讼均应中止，以待仲裁 。

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator. 双方同意，适用于卫生保健提供者的加州法律条款适用于本仲裁协议中的争议，包括但不限于民事诉讼法第 340.5 和 667.7 节以及《民法典》第 3333.1 和 3333.2 节。当事人可以依照民事诉讼法向仲裁员提出即决判决或者即决判决的动议。发现应根据《民事诉讼法》第 1283.05 条进行;但是，未经中立仲裁员事先批准，可以作出证词。

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Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.
声明四： **一般规定**：基于同一事件，交易或相关情况的所有索赔应在同一个程序中进行仲裁。该索赔将被放弃并永久禁止 如果 1）在收到通知之日，在民事诉讼中提出索赔, 则该索赔将因适用的加利福尼亚州《时效法令》而被禁止，或者 2）索赔人根据本文规定的程序以合理的努力提出索赔，但索赔失败。对于此处未明确规定的许多事项，仲裁员应受《加利福尼亚民事诉讼程序规则》中与仲裁有关的规定管辖。

Article 5: **Revocation:** The agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.
声明五： **撤销**：协议可于签署后 30 天内向医生发出书面通知撤销。本协议的意图是适用于任何时间提供的所有医疗服务。

Article 6: **Retroactive Effect**: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:
声明六：**追溯效果**：如果患者打算本协议涵盖在签署日期之前提供的服务（包括但不限于紧急治疗），患者应注名如下：

Effective as the date of first medical services
(自首次医疗服务之日起生效) _____
Patient or Patient Representative's Initials (患者或患者代表的首字母缩写)

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. (如果本仲裁协议的任何条款被认为无效或不可执行，其余条款应保持完全有效，且不受任何其他条款无效的影响.)

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy. 我理解我有权收到本仲裁协议的副本。通过下面的签名，我确认我已收到一份副本.)

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OR MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIALL SEE ARTICLE 1 OF THIS CONTRACT. (注意：签署本合同即表示您同意有由中立仲裁决定的任何问题或医疗事故，您放弃陪审团或法院审判的权利，请参阅本合同第 1 条.)

By (由) : _____ Date (日期) : _____
Physician of Authorized Representative's Signature (授权代表医师签名)

_____
Print of stamp Name of Physician, Medical Group, or Association Name
(正楷书写医生、医疗组或 协会名称的名称)

By (由) : _____ Date (日期) : _____
Patient or Patient Representative's Signature (患者或患者代表的签名)

_____
(Patient Name 患者姓名)

_____
(If Representative, Print Name/Relationship to Patient)
(如有代表人，请正楷书写姓名/与患者关系)

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HISTORY OF OCCURRENCE (事故问卷)

If your personal injury was **NOT** a motor vehicle accident collision, but was a slip and fall, or other type of injury, please answer all questions that apply to your injury. Please be specific. (如果您的人身伤害不是 车祸引起的，而是滑倒或其他类型的伤害，也请具体的回答所有适用于您的伤害的问题)

Date of accident (事故日期): _____ Time (发生的时间) : _____

Driver of car (司机) : _____

Where were you seated? (Please circle) 你坐在哪里? (请圈出) **:** Driver's seat (司机)

Front right seat (前面的右边) Front middle seat (前面的中间) Rear right passenger (后面的右边)

Rear middle passenger (后面的中间) Rear left passenger (后面的左边)

Who owns the car? (谁拥有这辆车?) _____

Year, Make, and model of car (汽车年份、品牌、车型) : _____

What was the approximate damage done to the car you were in? (你那辆车的大致损坏金额是多少)?

$_____

Visibility at the time of accident (Circle) 事故发生时能见度 (圈出) **:** Poor (很差) Fair (一般) Good (好)

Road conditions at the time of accident (Circle) 事故发生时路面状况 (圈出) **:**

Icy (结冰) Rainy/Wet (下雨/很湿) Clear (晴朗的天空) Dark (黑暗的)

Please check all that apply (请在所有适用处打勾**) :**

☐My car hit another car (我的车撞了另一辆车)

☐My car was hit on the (我的车被撞部位) : ☐Right (右) ☐ Left (左) ☐ Rear (后面) ☐ Front (前面)

Type of accident (事故类型) : ☐Head on collision (车头碰撞) ☐ Broad-side collision (侧面碰撞)

☐ Rear-end collision (后端碰撞)☐Front impact (rear-ended car in front) 前端碰撞（追尾前车）

☐Non-collision (Describe) 不是车祸 (描述) : _____

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Description of accident (请描述事故发生经过) :

_____
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SOUTHERN CALIFORNIA INJURY TREATMENT CENTER
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HIPAA Notice of Privacy Practices

本通知描述了如何使用和披露有关您的医疗信息，以及如何访问此信息。请仔细查看。

本隐私惯例声明描述了我们如何使用和披露您受保护的健康信息 （PHI） 进行治疗、支付或医疗保健操作 （TPO） 以及法律允许或要求的其他目的。它还描述了您访问和控制受保护的健康信息的权利。"受保护的健康信息"是有关您的信息，包括人口统计信息，这些信息可能表明您的身份，并且与您过去、现在或未来的身心健康或心理健康或状况及相关医疗保健服务有关。

受保护健康信息使用与披露受保护健康信息
您的受保护健康信息可能会由您的医生、我们的办公室工作人员和我们办公室以外的其他人使用和披露，这些员工参与您的护理和治疗，以便为您提供医疗保健服务、支付您的医疗保健账单、支持医生的执业以及法律要求的任何其他用途。

治疗：我们将使用和披露您受保护的健康信息，以提供、协调或管理您的医疗保健和任何相关服务。这包括协调或管理您的医疗保健与第三部分。例如，我们会将您受保护的健康信息（如有必要）披露给为您提供护理的心理健康机构。例如，您的受保护的健康信息可能提供给您被转诊的医生，以确保医生拥有诊断或治疗您的必要信息。

付款：将根据需要使用受保护的健康信息，以获得您的医疗保健服务付款。例如，获得住院许可可能需要将相关的受保护健康信息披露到健康计划，以获得住院批准。

医疗保健运营：我们可能会根据需要使用或披露您受保护的健康信息，以支持您医生执业的业务活动。这些活动包括但不限于质量评估活动、员工审查活动、员工审查活动、医科学生培训、许可以及进行或安排其他业务活动。例如，我们可能会向在办公室看病人的医学院学生披露您受保护的健康信息。此外，我们可能会在登记台使用登录表，要求您在登记台上签名并注明您的医生。当您的医生准备好见你时，我们也可能在候诊室按姓名呼叫您。如有必要，我们可能会使用或披露您受保护的健康信息，以提醒您预约。
未经您的授权，我们可能会在以下情况下使用或披露您受保护的健康信息。这些情况包括：根据法律规定，公共卫生问题由法律要求，传染病：卫生监督：滥用或忽视：食品和药物管理局要求：法律程序：执法：验尸官、丧葬主任和器官捐赠：研究：犯罪活动：军事活动和国家安全：囚犯：所需用途和披露：根据法律，我们必须向您披露，并在卫生和人力资源管理部部长要求时，调查或确定我们的遵守情况符合第 164.500 节的要求。
除非法律要求，否则只有在您的同意、授权或反对机会的情况下，才能进行其他允许和必需的使用和披露。您可以随时以书面形式撤销此授权，但您的医生或医生的执业根据授权书中指明的使用或披露而采取行动的延伸除外。

您的权利
以下是您关于受保护健康信息的权利声明。

您有权检查和复制受保护的健康信息。但是，根据联邦法律，您不得检查或复制以下记录;心理治疗笔记;在合理预期或使用民事、刑事或行政诉讼或程序时汇编的信息，以及受法律限制的受禁止获取受保护健康信息保护的健康信息。

您有权要求限制受保护的健康信息。 这意味着您可以要求我们不要出于治疗、付款或医疗操作的目的使用或披露您受保护的健康信息的任何部分。您还可能要求不得向可能参与您的护理的朋友的家庭成员披露受保护健康信息的任何部分，或出于本隐私惯例通知所述的通知目的。您的请求必须说明请求的特定限制以及您希望将限制应用于谁。您的医生不需要同意您可能要求的限制。如果医生认为允许使用和披露受保护的健康信息符合您的最佳利益，则受保护的健康信息将不受限制。然后，您有权使用其他医疗保健专业人员。

您有权要求通过其他方式或在替代地点接收我们的机密通信。

您有权应要求从我们那里获取本通知的纸质副本，即使您已同意以电子方式接受本通知。

您有权让您的医生修改您受保护的健康信息。 如果我们拒绝您的修改请求，您有权向我们提交不同意见的声明，我们可能会准备反驳您的声明，并将为您提供任何此类反驳的副本。

您有权收到我们对您受保护的健康信息（如果有）的某些披露的会计。
我们保留更改本通知条款的权利，并将通过邮件通知您任何更改。然后，您有权根据本通知中规定反对或撤回。

投诉： 如果您认为您的隐私权被我们侵犯，您可以向我们或卫生与服务部长投诉。您可以通过通知我们的隐私联系人您的投诉向我们投诉。 我们不会因您提出投诉而进行报复。

法律要求我们维护个人的隐私，并提供有关受保护健康信息的法律义务和隐私惯例的通知。如果您对此表格有任何异议，请亲自或通过电话咨询我们的 HIPAA 合规官。

SPECTRUM MRI IMAGING CENTER
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PATIENT HEALTH HISTORY (患者健康史)

Name (名字) : _____ Family Physician (家庭医生) : _____

FAMILY HISTORY (CIRCLE ALL THAT APPLY) 家庭病史（请圈出）

Mother (妈妈) : A) Cancer (癌症) B) Diabetes (糖尿病) C) Heart Disease (心脏病) D) High Blood Pressure (高血压) E) Respiratory Problems (呼吸问题) F) Kidney (肾问题) G) Stroke (中风) H) In good health (身体健康) I) If deceased (如果死亡) – age of death (死亡年龄) _____

Father (爸爸) : A) Cancer (癌症) B) Diabetes (糖尿病) C) Heart Disease (心脏病) D) High Blood Pressure (高血压) E) Respiratory Problems (呼吸问题) F) Kidney (肾问题) G) Stroke (中风) H) In good health (身体健康) I) If deceased (如果死亡) – age of death (死亡年龄) _____

Siblings (兄弟姐妹) : A) Cancer (癌症) B) Diabetes (糖尿病) C) Heart Disease (心脏病) D) High Blood Pressure (高血压) E) Respiratory Problems (呼吸问题) F) Kidney (肾问题) G) Stroke (中风) H) In good health (身体健康) I) If deceased (如果死亡) – age of death (死亡年龄) _____

SOCIAL HISTORY: (CIRCLE ALL THAT APPLY) 社会历史：（请圈出）

MARITAL STATUS (婚姻状况) : 1. SINGLE (单) 2. MARRIED (已婚) 3. DIVORCED (离婚) 4. WIDOWED(丧偶)

NUMBER OF CHILDREN (几个小孩) : (0) (1) (2) (3) (4) (5)

DO YOU （你有) : 1. EXERCISE REGULARLY (定期锻炼) _____ 2. EAT A BALANCED DIET? (吃均衡的饮食?) _____

3. OBTAIN SUFFICIENT REST? (获得足够的休息?) _____

DO YOU DRINK COFFEE/TEA? HOW MANY CUPS/DAY? (你喝咖啡/茶吗?每天喝几杯?): _____

DO YOU SMOKE? HOW MANY PACKS/DAY? (你抽烟吗？每天烟几包?) : _____

DO YOU DRINK ALCOHOL? HOW MANY DRINKS PER DAY? (你喝酒吗？每天喝几杯?)_____

MEDICAL HISTORY: CIRCLE ALL THAT APPLY (病史：圈出所有适用)

A) CHILDHOOD ILLNESSES (儿时疾病) : 1) MEASLES (麻疹) 2) MUMPS (腮腺炎) 3) CHICKENPOX (水痘) 4) TUBERCULOSIS (结核)5) RHEUMATIC FEVER (风湿热) 7) OTHER (其他) : _____

LIST OF ANY BIRTH DEFECTS (列出任何先天性缺陷) : _____

HOSPITALIZATIONS & SURGERIES: If you have ever been hospitalized, list reason, and dates.
住院及手术：如果您曾经住院，请列出原因和日期。

_____M/D/Y ___/___/___
_____M/D/Y ___/___/___
_____M/D/Y ___/___/___
_____M/D/Y ___/___/___

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B)ADULT/ILLNESSES/INJURIES(成年后疾病/创伤): 1) DIABETES 2) HEART DISEASE 3) HIGH BLOOD PRESSURE 4) SEIZURES 5) CANCER 6) OTHER

Also list injuries for which you have not been hospitalized; include approximate dates. 成人/疾病/伤害： 1) 糖尿病 2) 心脏病 3) 高血压 4) 癫痫发作 5) 癌症 6) 其他. 还要列出您未住院 的受伤情况，包括大致日期。

_____M/D/Y ___/___/___
_____M/D/Y ___/___/___
_____M/D/Y ___/___/___

MEDICATIONS: LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING OR HAVE TAKEN ON A REGULAR BASIS IN THE LAST SIX MONTHS (INCLUDE HOME REMEDIES) 药物：列出您当前正在服用或定期服用过去六个月的所有药物（包括在家里采用的缓解类用药）

A)_____ B)_____C)_____
D)_____ E)_____F)_____

PAIN LEVEL WITH MEDICATIONS (服药后疼痛水平) : _____/10 PAIN LEVEL WITH OUT MEDICATION (不服药疼痛水平) : _____/10

MEDICATIONS TO WHICH YOU ARE ALLERGIC (过敏药物) :

A)_____ B)_____C)_____
D)_____ E)_____F)_____

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Name (名字): _____ Date (日期): _____

Date of Injury (受伤日期): _____

HEAD TRAUMA SYMPTOMS (头部创伤症状)

Please **circle** all symptoms you currently have **that you did not have** before the accident.**请圈出**您目前出现的所有**在事故发生后出现的症状**。

NEUROGICAL SYMPTOMS (神经症状) :

Numbness(麻木) | Tingling Arm/Hand(刺痛手臂/手) (Left 左/Right 右)
Weakness Arm/Hand (虚弱 臂/手) (左/右 Left/Right)
Numbness 麻木 |Tingling Leg/Foot(刺痛腿/脚) (Left 左/Right 右)
Weakness Leg/Foot (虚弱 腿/脚) (Left 左/Right 右)

BRAIN 大脑/NEUROPSYCH 神经心理/MTBI SYMPTOMS MTBI 症状:

Range of motion problems (身体运动范围受限)
Headaches (头痛)
Muscle spasms (肌肉痉挛)
Dizziness (头晕)
Visual disturbances (视觉干扰)
Sleep disruption (睡眠中断)
Radiating pain (放射性疼痛)
Anxiety (焦虑症)
Depression (抑郁症)
Wanting to be alone (想独处)
Sleepiness (睡意)
Nausea(恶心) / vomiting (呕吐)
Difficulty concentrating (不能专心)
Day dreaming/Mindless staring (白日做梦/无心凝)
Mood swings (情绪波动)
Agitation (内心)
Sadness or tearful (悲伤或泪流满面)
Blurry vision (模糊视力)
Double vision (双视)
Disoriented (迷失方向)
Confused (处于混乱状态)
Difficulty speaking (说话困难)
Feeling isolated from others (感觉与别人隔绝)
Attention problems (注意力问题)
Appetite changes (胃口变化)
Pupils different size (不同尺寸的瞳孔)
Room spinning/woozy feeling (房间会旋转/昏昏欲睡的感觉)
Balance problems (平衡有问题)

Very tired/dozing during the day(白天很累/打瞌睡)
Personality changes (个性变化)
Cannot remember numbers (不记得数字)
Reading problems (阅读有问题)
Writing problems (写作有问题)
Difficulty with adding/subtracting (添加/减法有问题)
Poor attention (注意力不重视)
Difficulty learning new things (学习新事物有困难)
Re-reading things to understand it (需要重读事物在能理解)
Anger (愤怒)
Difficulty making decisions (决策有困难)
Change in sexual function (性功能有变化)
Reduced confidence (信心降低)
Helplessness (无奈)
Apathy (don't care) (冷漠/不在乎)
Irritable (暴躁)
Change in sense of taste or smell (味觉或嗅觉有变化)
Flashbacks to accident (闪回事故)
Impatience (急躁)
Change in sense of taste or smell (味觉或嗅觉有变化)
Flashbacks to accident (闪回事故)
Impatience (急躁)
Frustration (挫折)
Hearing problems (听力有问题)
Difficulty planning or organizing (规划或组织有困难)
Difficulty walking (行走有困难)
Difficulty focusing/easily distracted(注意力不集中/容易分心)
Taking over the counter pain medication (吃服用止痛的药)

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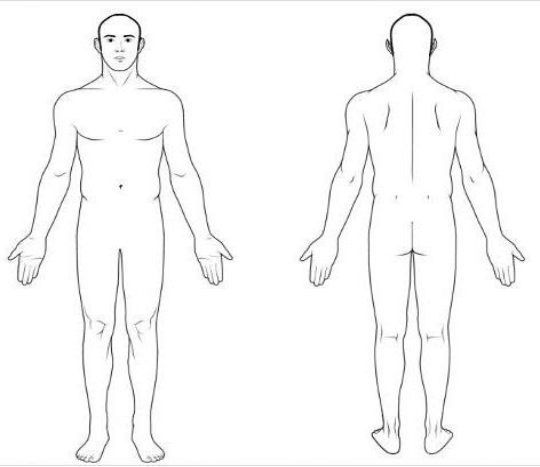
NAME (名字) : _____

DATE OF BIRTH (出生日期): _____ DATE OF SERVICE (服务日期) : _____

PAIN DRAWING INSTRUCTIONS: PLEASE MARK THE AREAS ON YOUR BODY THAT YOU ARE HAVING PAIN
(疼痛图说明:请圈出并编号您身体疼痛的地方)



NO PAIN (没有疼痛) WORSE PAIN (很痛)
1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

BODY PART 身体部位	WITH MEDICATION 吃药	W/O MEDICATION 没有吃药
1.	/10	/10
2.	/10	/10
3.	/10	/10
4.	/10	/10
5.	/10	/10

PLEASE INDICATE AND CIRCLE IF YOU HAVE ANY DIFFICULTY/LIMITATIONS WITH THE FOLLOWING ACTIVITIES OF DAILY LIVING
(如果您有任何生活活动的困难/限制，请在下面圈出)：

CIRCLE ALL THAT APPLY (圈出所有适用的):	YES 有困难	NO 没有困难	Do medications ease this difficulty? (药物能缓解这种困难吗?) YES 是 /NO 否
BATHING (洗澡) DRESSING(穿衣) EATING (吃东西)			
BRUSHING TEETH (刷牙) COMBING HAIR (梳头发)			
TOILETING (URINATING, DEFECATING)上厕所（排尿, 排便）			
WRITING (写字) TYPING (打字) SEEING (视力) RECLINING (躺下) WALKING (走路)			
CLIMBING STAIRS (走楼梯)			
HEARING (听力) TACTILE FEELING (触觉的感觉) TASTING (味觉) SMELLING (嗅觉)			
GRASPING (抓) LIFTING (提起物品) TACTILE DISCRIMINATION (触觉辨别)			
RIDING (骑车) DRIVING (开车) FLYING (坐飞机)			
SEXUAL FUNCTION (性功能)			
SLEEP(睡觉) RESTFULNESS (休息) NOCTURNAL SLEEP PATTERNS (夜间睡眠模式)			

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ANY CHANGES TO YOUR CURRENT MEDICATIONS? (IF YES, PLEASE DESCRIBE)
您当前的药物有什么变化吗？（如果有，请描述说明) :

_____

ANY NEW ALLERGIES? (IF YES, PLEASE DESCRIBE)
有新的过敏吗? (如果有，请描述说明):

_____

_____

DO YOU EXPERIENCE ANY SIGNIFICANT SIDE EFFECTS WITH ANY PRESCRIBED MEDICATIONS? YES OR NO ? IF YES, PLEASE DESCRIBE
你有没有服用过处方药对您具有显著的副作用吗?

_____

DO ANY OF THE FOLLOWING HELP WITH YOUR PAIN? (EX: CHIRO, ACUPUNCTURE, PHYSICAL THERAPY, HOT/COLD)
PLEASE DESCRIBE 您有没有接受过以下治疗缓解疼痛?（例如：脊椎复健治疗，针灸，物理治疗，热/冷敷，如果有, 请描述说明 :

_____

_____

SIGNATURE (签名) : _____ DATE (日期) : _____

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