35 Island Dr. Suite 14
Mail: P.O. Box 300
Eastpoint FL 32328
Phone: 850.660.9078

Patient Registration Packet

Today's Date:_____

Patient Last Name: _____ First Name: _____ Middle-Initial: _____

Previous Name (if applicable): _____

Address: _____ City: _____ Zip: _____ State:____

Home Phone: (____)_____ Cell Phone: (____)_____ Work Phone: (____)_____

Email: _____ Date of Birth:_____/_____/_____

Social Security: _____ Sex: ___Male ___Female ___ Unknown ___ Other

Sexual Orientation

□ Lesbian, Gay, or Homosexual
□ Straight or Heterosexual
□ Bisexual
□ Do not know
□ Choose not to disclose
□ Something else (please describe):

Gender Identity

□ Male □ Female
□ Female to Male/Transgender Man
□ Male to Female/Transgender Woman
□ Genderqueer, not Male nor Female
□ Choose not the disclose
Additional gender (please describe):

Marital Status:
___Divorced_____Married_____Partner_____Single_____Unknown_____Widowed_____Separated

Primary Language:_____Translator Required:_____Yes_____No

Race

☐ Asian
☐ Asian Indian
☐ Black or African American
☐ Chinese
☐ Filipino
☐ Guamanian or Chamorro
☐ Japanese
☐ Korean
☐ Native American or Alaska Native
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Samoan
☐ Vietnamese
☐ White
☐ Other Race
☐ Declined to Specify

Release of Information: (HIPAA) ___Yes ___No

Rx History Consent: ___Yes___ No

Advanced Directive: ___N/A (Not applicable) ___Yes ___No

Employment: __Full-time___Part-time___Not Employed___Self-employed___Retired ___Military active duty

Student Status: ___Full-time ___ Part-time ___Not a Student

Patient Name:_____ Date of Birth: ____/____/____

Primary Insurance	Secondary Insurance
Name:	Name:
Insured Name:	Insured Name:
Policy Number:	Policy Number:
Relation to Insured	Relation to Insured

Responsible Party		
Name:	Date of Birth:	
Address:	Relation:	Phone:

Emergency Contact:_____ Phone Number: _____

Relation: _____ Address: _____

Patient's Alternate Name, if applicable (Last, First, MI): _____

Insured's Alternate Name, if applicable (Last, First, MI):_____

Consent and Financial Responsibility Agreement

I/We hereby grant Forgotten Coast Healing Center's (FCHC) permission to treat myself and/or my child/ward for any illness or injury that I/we may encounter as well as provide my wellness/preventative care that is recommended based on my age or medical condition. I/We hereby authorize FCHC to furnish all information regarding my medical history, diagnosis and treatment of myself, or my child (if applicable) to an insurance company regarding my claims for benefits. If however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, I/we agree to be responsible for the fee and cost involved in the treatment of the above named patient. I/We authorize payment of medical benefits to FCHC and agree that should I receive any payments directly from any insurance companies for services billed on my behalf by the center, that I will turn those payments over to FCHC immediately. I further understand that should my account have to be referred to a collection agency that I am responsible for all fees and costs incurred therein. I/We hereby authorize FCHC to act on my behalf in accessing my medical records when and if

_____ _____

Patient's or Parent/Legal Guardian Signature **Patient's Name (Print) and Date**

Patient Name:_____ Date of Birth: ____/____/____

Patient Medical, Family, Social History

Please fill out the following sections as completely and accurately as possible so that we may provide you the best quality of care.

Current Medications: _____

_____

_____

PAST MEDICAL HISTORY

Do you have/had any of the following?

☐ AIDS/HIV or exposure to	☐ Congenital abnormalities	☐ Hyperlipidemia	☐ Seizures/convulsions
☐ Alcohol abuse	☐ Congestive heart ☐ failure	☐ Immune Disorders	☐ Sexually transmitted disease
☐ Anxiety	☐ COPD	☐ Kidney disease (renal)	☐ Sinusitis
☐ Arthritis	☐ Dementia	☐ Liver/stomach/bowel ☐ problems	☐ Skin problems
☐ Asthma	☐ Depression	☐ Migraine headaches	☐ Thrombophlebitis
☐ Bipolar	☐ Chest pain	☐ Obsessive Compulsive	☐ Thyroid disease
☐ Bleeding problems	☐ Diabetes	☐ Parkinson's disease	☐ TIA or Stroke
☐ Bronchial	☐ Heart (cardiac) disease	Pulmonary embolism	☐ Tuberculosis (TB)
☐ Cancer What Type?	☐ Hepatitis (A) (B) (C) carrier or exposure	☐ Reflux/GERD	☐ ***Other:***
	☐ High Blood Pressure	☐ Schizophrenia	

Drug Allergies/Reactions: _____

_____

_____

Pharmacy	**Primary**	**Secondary**
Name		
Phone		
Location		

Patient Name:_____ Date of Birth: ____/____/____

SURGICAL HISTORY

☐ Abdominal	☐ Cholecystectomy	☐ Intestinal bypass	☐ Skin/dermal
☐ Angioplasty	☐ Colectomy	□Joint replacement	☐ Small bowel resection
☐ Aortic aneurysm repair	☐ Colostomy, partial	☐ Kidney	☐ Thyroid
☐ Appendectomy	☐ Coronary artery bypass graft	☐ Laminectomy/ discectomy	☐ Tonsillectomy
☐ Arthroscopy knee	☐ Delivery by C- section	☐ Lithotripsy	☐ Tubal ligation
☐ Back surgery	☐ Ears, nose, throat	☐ Mastectomy	☐ TURP
☐ Bladder	☐ Gastric, other	☐ Neurosurgery	☐ Ulcer
☐ Breast biopsy	☐ Gastroplasty, bariatric	☐ Oophorectomy	☐ Other surgery. Explain:
☐ Cardiothoracic	☐ Hernia	☐ Open lysis adhesions	
☐ Carpal tunnel	☐ Hip replacement	☐ Orthopedic	
☐ Cataract/lens implant	☐ Hysterectomy	☐ Prostate	

Previous Hospitalizations and Dates: _____

_____

_____

Patient Name:_____ Date of Birth: ____/____/____

SOCIAL HISTORY

Family Characteristics: # of Adults in Household _____ # of Children in Household _____

Communication Needs:

Hearing? _____ Yes _____No Vision? _____ Yes _____ No Cognition (understanding)? _____Yes _____ No

Do you consider yourself a social person? _____ Yes **_____** No

Most recent Hospital/ER:

Visit date _____/_____/_____ Follow-up date _____/_____/_____ Discharged _____Yes _____ No

Tobacco Use:

___Smoker ___ Former Smoker ___Nonsmoker How many/how often? _____
___Chew tobacco ___ Pipe Smoker ___Snuff user Are you another tobacco user? ___Yes ___No

Sexual History:

Had sex in the past 12 months (vaginal, oral, or anal)? ___ Yes ___ No

Have you had any sexually transmitted disease (STD)? ___ Yes ___ No

Last menstrual period (LMP) _____/_____/_____

___ Depo Provera ___ Mirena ___ Post-menopausal ___ Uterine Ablation

Are you having any sexual problems? ___ Yes ___ No

How many sexual partners have you had? _____

Use condoms: ___ Yes ___ No Use other birth control method: _____

Any sexual abuse? ___ None ___ Has safety plan ___ History in the past ___ Ongoing in relationship

Drugs/Alcohol:

Have you used drugs other than those for medical reasons in the past 12 months? ___ Yes ___ No If "Yes" which drug(s)

_____

Did you have a drink containing alcohol in the past year? ___ Yes ___ No

If "Yes" how often? ___Never ___ Monthly or less ___ 2-4 a month ___ 2-3 times a week ___ 4 or more a week

Caffeine intake daily: ___ None ___ 1-2 cups ___ 2-3 cups ___ 3-4 cups ___ more than 4 cups

Other Caffeine: ___ Chocolate ___ Soda ___ Pills ___ Other How much/how often? _____

Patient Name:_____ Date of Birth: ____/____/____

Consent for the Use and Disclosure of Individually Identifiable Health Information for Treatment, Payment, and/or Health Care Operations

I understand that as a part of my health care, **Forgotten Coast Healing Center** (FCHC) receives, originates, maintains, discloses, and uses individually identifiable health information, including, but not limited to, health records and other health information describing my health history, symptoms, examination and test results, diagnosis, treatment, treatment plans, and billing and health insurance information. I understand that FCHC and its physicians, other health care professionals, and staff may use this information to perform the following tasks:

- Diagnose my medical psychiatric/psychological condition.
- Plan my care and treatment.
- Communicate with other health professionals concerning my care.
- Document services for payment/reimbursement.
- Conduct routine health care operations, such as quality assurance and peer review.
- For research and similar purposes designed to improve the quality and to reduce the cost of healthcare.

I have been provided a NOTICE OF INFORMATION PRACTICES that fully explains the uses and disclosures that FCHC will make with respect to my individually identifiable health information. I understand that I have the right to review the NOTICE before signing this consent. FCHC has afforded me sufficient time to review this NOTICE and has answered any questions that I have to my satisfaction. I also understand that FCHC cannot use or disclose my individually identifiable health information other than as specified on the NOTICE. I also understand, however, that FCHC reserves the right to change its notice and the practices detailed therein prospectively (for uses and disclosures occurring after the revision) if it posts a copy of the revised notice in a prominent space in the medical center(s).

I understand that I do not have to consent to the use of disclosure of my individually identifiable health information for treatment, payment, and health care operations, but that if I do not consent, FCHC may refuse to provide me health care services unless applicable state or federal law requires FCHC to provide such services.

I understand that I have the right to request restrictions on the use or disclosure of my individually identifiable health information to carry out treatment, payment, or health care operations. I further understand that FCHC is not required to agree to the requested restriction but that, if it does agree, it must honor the restriction unless I request that it stop doing so or FCHC notifies me that it is no longer going to honor the request.

I understand that I have the right to request restriction as to the method of communications to me. I understand that I may revoke this consent in writing but that the revocation will not be effective to the extent that FCHC has already taken action in reliance on my earlier effective consent.

Patient or Legal Guardian Signature: _____

Date _____

I object to uses and disclosures as follows:

_____

_____

Patient Name:_____ Date of Birth: ____/____/____

UNIVERSAL PATIENT AUTHORIZATION FORM FOR
FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND QUALITY OF CARE

****PLEASE READ BOTH PAGES BEFORE SIGNING BELOW****

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): _____

Date of Birth (mm/dd/yyyy):_____

Address: _____City: _____ State: _____ Zip:_____

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure:

OF WHAT: **ALL MY HEALTH INFORMATION including any information about sensitive conditions** (if any) [See page 2 for details]

FROM WHOM: ALL information sources [See page 2 for details]

TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name:_____ Phone: (____)_____

Address:_____ Fax: (____)_____

PURPOSE: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission.

REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read all pages of this form and agree to the disclosures above from the types of sources listed**.

X_____ _____

Signature of Patient or Patient's Legal Representative Date Signed (mm/dd/yyyy)

_____

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

☒ Parent of minor ☒ Guardian ☒ Other personal representative (explain: _____)

Patient Name:_____ Date of Birth: ____/____/____

Explanation of Form Florida AHCA FC4200-004
"Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"Of What": includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. **All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:**
    a. Drug, alcohol, or substance abuse
    b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
    c. Sickle cell anemia
    d. Birth control and family planning
    e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
    f. Genetic (inherited) diseases or tests
2. **Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.**
3. **Information created before or after the date of this form**.

"From Whom" includes: **All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom": For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

"Purpose": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

"Revocation": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses by giving written notice. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re–disclosure of Information": Any health information about you may be re–disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re–disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200–005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.

Patient Name:_____ Date of Birth: ____/____/____

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from the Forgotten Coast Healing Center. A summary of your rights and responsibilities follows:

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

MISSION: To increase access to quality health care and improve the overall health of the community.

AS A PATIENT, YOU HAVE THE RIGHT TO:

1. Be treated with courtesy and respect, with appreciation of your individual dignity, and with protection of your need for privacy.
2. Prompt and reasonable response to questions and requests.
3. Know who is providing medical services and who is responsible for your care.
4. Know what patient support services are available, including whether an interpreter is available if you do not speak English.
5. Know what rules and regulations apply to your conduct.
6. Be given, by the health care provider, information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
7. Refuse any treatment, except as otherwise provided by law.
8. To be given, upon request, full information and necessary counseling on the availability of known financial resources for your care.
9. (If you are a patient eligible for Medicare), to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
10. To receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
11. Receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
12. Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
13. Treatment for any emergency medical condition that should deteriorate from failure to provide treatment.
14. Know if medical treatment is for purposes of experimental research and to give your consent or refusal to participate in such experimental research.
15. Express grievances regarding any violation of your rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility that served you and to the appropriate state licensing agency.

AS A PATIENT, YOU HAVE THE RESPONSIBILITY TO:

1. Provide to the health care provider, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to your health.
2. Reporting unexpected changes in your condition to the health care provider.
3. Reporting to the health care provider whether you comprehend a contemplated course of action and what is expected of you.
4. Following the treatment plan recommended by the health care provider.
5. Keeping appointments and, when you are unable to do so for any reason, notifying the health care provider or health care facility.
6. Be responsible for your actions if you refuse treatment or do not follow the health care provider's instructions.
7. Assuring that the financial obligations of your health care are fulfilled as promptly as possible.
8. Following health care facility rules and regulations affecting patient care and conduct.

Patient Name:_____ Date of Birth: ____/____/____

RECEIPT OF PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

I,_____(Print name) have received a copy of the

Patient Bill of Rights and Responsibilities and have read them or had them read to me.

_____

Signature of Patient Date

Patient Name:_____ Date of Birth: ____/____/____

To My Patients:

Under the Patient Self-Determination Act, Florida Statute 765, we are required to provide information to you regarding Health Care Advance Directives. It is your right under law to accept or refuse medical care. Advance Directives can protect this right if you ever become mentally or physically unable to choose or communicate your wishes due to an accident or an illness.

An Advance Directive is any instruction you give relating to the provision of healthcare in the event you become unable to make your own decisions. Examples of Advance Directives include Living Will; Durable Power of Attorney; Appointment of a Healthcare Surrogate. When using Advance Directives, you protect your right to make medical choices that can affect your life; your family can avoid the responsibility and stress of making difficult decisions; and your physicians will have guidelines for providing your care.

Living Wills are written instructions that explain your wishes regarding healthcare should you have a terminal condition such as cancer, Alzheimer's disease, etc. They are called Living Wills because they take effect while the patient is still alive.

Durable Power of Attorney for Healthcare allows you to name a person (called a surrogate/proxy) to make decisions for you if you become unable to do so. Also in the Power of Attorney, you may list the healthcare decision that you desire concerning life-prolonging care, treatment, services and procedures, as well as special provisions and limitations. These life-prolonging measures may include cardiopulmonary resuscitation (CPR), intravenous therapy, feeding tubes, respirators, dialysis, pain relief, Do Not Resuscitate orders, and organ donation.

Healthcare Surrogate (Proxy) is a person you choose to make healthcare decisions for you if you are not able to do so for yourself. This person should be someone who knows your wishes and who will make decisions on what he/she believes you would want.

Once you have completed your Advance Directive, please discuss the details of the directive with your physician, family members, minister, surrogate and/or close friends. Make sure your surrogate has a copy of your Advance Directives, place a copy in the glove compartment of your car and give copies to those whom you feel should know.

If you need help in preparing Advance Directives or if you would like more information, you may contact a lawyer, your State Attorney General's office, Hospitals, Hospices and Long-Term Care Facilities. You may also seek information and assistance at your next scheduled visit with us.