HEART OF FLORIDA HEALTH CENTER

Health Care Application

*must be updated annually

PATIENT INFORMATION

Last Name	First Name	MI	DOB (MM/DD/YY)	SS#

Street Address	City	State	Zip	County

Is Patient Insured?
Medical: □ Yes □ No
Dental: □ Yes □ No

If Patient under 18:
Mother's/Guardian Name ______________________________ Date of Birth: _____ /_____/______
Father's/Guardian Name ______________________________ Date of Birth: _____ /_____/______

CONTACT INFORMATION

Primary Phone Number □ **Home** □ **Cell**
Secondary Phone Number □ **Home** □ **Cell**

HFHC may contact me for clinical/appointment reminders by the following methods: (check all that apply)
□ **Text message** (Standard data/messaging rates may apply) □ **Email:**________________________________

Emergency Contact: ____________________________ *Relationship:* ___________ *Phone #:* _________________

Please confirm if you have an Advance Directive: □ Yes □No
(legal document that goes into effect if you are incapacitated or unable to speak for yourself- states your values and desires related to end-of-life care)

PATIENT DEMOGRAPHICS

Primary Language Spoken
□ English □ Spanish
□ Other:________________________________

Would you like an interpreter?
□ Yes □No

Race (Check all that apply)
□ Asian □ Black □ White
□ Central American Indian
□ American Indian/Native Alaskan
□ Pacific Islander □ Native Hawaiian
□ Other: _____________
□ Declined to Specify

Ethnicity
□ Hispanic/Latino
□ Non-Hispanic/Latino
□ Refused to report

Gender Identity:
Do you think of yourself as:
□ Male
□ Female
□ Transgender (□ Male-to-Female □ Female-to-Male)
□ Other, please specify:
□ Prefer not to disclose

Sexual Orientation:
Do you think of yourself as?
□ Straight or heterosexual
□ Lesbian, gay, or homosexual
□ Bisexual
□ Prefer not to disclose
□ Something else ____________

Marital Status
□ Single
□ Married
□ Divorced
□ Widowed
□ Partner

Student
□ Full-Time
□ Part- Time
□ Not a student

Employment Status
□ Full-Time
□ Part Time
□ Un-Employed
□ Retired

Employer **Zip Code**

Migratory or Seasonal Agricultural Worker?
□ Yes □ No

Military Veteran?
□ Yes □ No

How Did You Hear About the Health Center? Circle One
Family Friend Flyer Hospital Local Organization Health Fair Internet Other:_____________

PREFERRED PHARMACY: ____ **(include address)**
***If not completed HFHC will default this section to our internal pharmacy.**

Would you like to learn more about our **sliding fee scale program** and a possible discount on your bill? □ **Yes, Interested**

Gross Household Income (Before Taxes):
$_________________ □ Monthly □ Annually
 # Adults & Children In Household: _____________

□ **Prefer not to disclose income.**
Services not covered by your 3rd party insurance may be eligible for discount depending on your income level. If you do not wish to disclose your income, you will be responsible for any balance not paid by 3rd party insurance.

INSURANCE

Primary Medical Insurance: ____
Subscriber Number: ____
Policy Holders Name: ____________________________ □Self □Parent □Spouse
Policy Holders Date of Birth: _____ /_______/__________

Secondary Medical Insurance: ___________________________________
Subscriber Number: ____
Policy Holders Name: _______________________ □Self □Parent □Spouse
Policy Holders Date of Birth: _____ /_______/_________

Patient/Parent/Legal Guardian Signature: ____ Date: _____________

All patients are requested to read, initial, and comply with Heart of Florida Health Center's (HFHC) policies below. If you have any questions about our policies, please ask to speak with our front desk personnel.

Notice of Patient Privacy Practices

I understand that as a patient of Heart of Florida Health Center, all information collected will be kept confidential under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I acknowledge that I have received the Notice of Privacy Practices from Heart of Florida Health Center.

Patients Initials Here: ________

Appointment Expectations:

Please arrive 30 minutes prior to your appointment to register. All payments are expected at time of service. Alert a staff member of any changes in your information to make sure we have the most updated information in your account. Make sure you provide proper identification, required documentations, and insurance cards (if any) at the time of the visit. Minors must always be accompanied by an adult.

Patients Initials Here: _________

Appointment Confirmation

Your appointment must be confirmed 24 hours before the scheduled appointment. We will do everything possible to reschedule your appointment depending on the availability of your provider.

Patients Initials Here: _________

Late Arrival

Patients that **arrive** at the front desk **more than 15 minutes after their scheduled appointment** *(10 mins for dental appointments)* will not be seen. We will do everything possible to reschedule your appointment depending on the availability of your provider.

Patients Initials Here: ________

Cancellation/No Show Policy

Patients that need to cancel or reschedule an appointment may do so by calling Heart of Florida Health Center at 352-732-6599. **Appointment cancellation requires 24-hour advanced notice.** Failure to cancel an appointment will result in a **"no-show"** entry in your record. Patients that fail to keep or cancel their appointments ***3 times in a 12 month period or 5 times*** *for children under the age of 18* may be prevented from scheduling future appointments for a period of six months and will be seen on a same-day or walk-in basis only. **This will require for you to call the clinic to verify if there are appointments available to be seen on that same day.**

Patients Initials Here: _______

Primary Care Physician Assignment

Patients who are covered by certain managed care health plans need to assign Heart of Florida health Center as their Primary Care Physician at the time of their appointment. Patient may coordinate with insurance plan for re-assignment and be seen with a confirmation number provided by the insurance company. If re-assignment is not completed in 30 days patient will be billed for the full fee of their office visit. Most importantly no referrals nor prior authorizations can be processed until assignment is completed.

Patients Initials Here: ________