AGREEMENT FOR TREATMENT

Medical Consent for Treatment: The undersigned consents to the furnishing of any and all examinations, treatments, procedures, laboratory procedures, drugs and supplied to the patient as ordered or requested by the patient's practitioner(s) and acknowledges that no guarantee or assurance has been made as to the results of such treatments, procedures, or examinations. Heart of Florida Health Center reserves the right to require an adult be present during the treatment of minors.

Patient/guarantor agreement: I agree, whether I sign as agent or patient, that, in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay and unconditionally guarantee payment of the patient's account(s) in accordance with the regular rates and terms. Payment in full is expected on a timely basis. I understand that I will not be refused treatment based on inability to pay.

Insurance Assignment of Benefits: I, the undersigned, authorize and assign payment of all medical and/or surgical insurance benefits to Heart of Florida Health Center for any services furnished to me.

Medicare Lifetime Assignment of Benefits: I request that payment of authorized Medicare benefits be made on payable on my behalf to Heart of Florida Health Center for any services furnished to me. I authorize any holder of medical information about me to release to The Centers for Medicare and Medicaid services and its agents any information needed to determine these benefits or the benefits of related services. I understand my signature requests that payment be made and authorizes release of the medical information necessary to pay the claim. This assignment is in effect until revoked by me in writing.

Emergency Room: If I am sent to the Emergency Room, I am responsible for payment to the hospital. If I require an ambulance to transport me to the hospital, I understand that I am responsible for any charges.

Patients' Bill of Rights and Responsibilities: By signature below, the patient acknowledges that the patient has received a copy of the "Patients Right and Responsibilities".

Pharmacy Benefit Management: By signature below, the patient/ parent/guardian authorizes Heart of Florida Health Center (HFHC) to obtain pharmacy and prescription information needed for accuracy and continuity of care.

Release of information: The undersigned authorizes Heart of Florida Health Center (HFHC) to disclose and release all or any part of the patient's record to any person or corporation which is or may be liable under a contract to HFHC or to the patient, or to a family member or employer of the patient for all or part of the charges, (including but not limited to hospital or medical service organizations, insurance companies, Medicaid, welfare funds, or the patient's employer).

Consent for Use and Disclosure of Protected Health Information: By signing below, I hereby consent to Heart of Florida Health Center (HFHC), its business associates, and any other healthcare provider involved in the patient's care using and disclosing all or any part of the patient's record for treatment and normal health care operations purposes.

By signing below, I also hereby consent to Heart of Florida Health Center (HFHC), its business associates, and any other provider involved in the patient's care using and disclosing all or any part of the patient's record for the purpose of securing payment for services rendered by the health care center. Unless otherwise indicated, the information to be released includes all the information to the patient's record including (if applicable) information about HIV testing and test results, psychiatric treatment, and treatment for alcohol or drug abuse, unless specific instructions are given below to withhold particular information.

Withhold the following information from release _____

The foregoing restriction(s), if any, do not restrict the use and disclosure of the patient's record for treatment and normal healthcare operations. The consent will remain in effect until revoked, except to the extent that action has been taken in reliance upon it.

For a more detailed description of uses and disclosures for treatment, payment, or healthcare operations, please review the Notice of Privacy Practices.

Notice of Privacy Practices: By signature below, I acknowledge that I have received today, or during a prior visit, a copy of the Notice of Privacy Practices.

I hereby certify that I have read or have had the foregoing information explained, that I have received a copy, and that I am the patient or am duly authorized to execute the above and accept its terms.

_____

Patient or Patient's representative Date

_____

If Patient's representative describe relationship

_____

Witness Date

DESIGNATION DISCLOSURE FORM

Designation of Relatives, Friends or Caregivers as Personal Representatives

I. ( ) My personal health information may NOT be released to any of the above listed individuals

OR

( ) I authorize HFHC to disclose my personal health information to the following people who may be involved in my care now or in the future.

PRINT NAME: RELATIONSHIP:

_____ _____

_____ _____

_____ _____

This Designation Disclosure Form will remain in effect for a period of one (1) calendar year unless terminated by me in writing.

II. Print Name of Patient: _____ **Date of Birth**: _____
Signature of Patient/Parent/Guardian: _____ Date: _____
Witness/Staff signature: _____ Date: _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Heart of Florida Health Center. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire one (1) calendar year from the date signed. I further understand that authorizing the release of my health information is voluntary. I can refuse to designate anyone in order to assure treatment. I understand that I may inspect or request a copy of information to be released as provided in C.F.R. 164.524. I understand any release of information carries with it the potential for re-release by the recipient and once authorized to be released, the information may not be protected by the federal confidentiality rules. If I have questions regarding the release of my health information, I can contact Heart of Florida Health Center's Privacy Officer at 352-732-6599

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
□ PartTime
□ 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.**

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) 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 and Financial Responsibility

We request that all new patients 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: _____

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: _____

HEART OF FLORIDA HEALTH CENTER
SLIDING FEE APPLICATION

Heart of Florida Health Center is a Non-Profit Organization that receives a defined amount of Federal funding to supplement the cost of providing Medical/Dental care to patients who are eligible to participate in the sliding fee scale program. Eligible patients will also qualify for reduced cost prescriptions. To determine your eligibility for this federally funded program, verification of your income is required. **You must update this information at least annually to continue your participation in the program. This information is only used to calculate your discount and is kept confidential.**

Patient Name: _____Social Security_____-____-_____DOB___-___-____

I would like to apply for Heart of Florida Health Center Sliding Fee: ☐Yes ☐No

Household Size # of Adults _____ #of Children_____ Total # _____

A Household constitutes any group of individuals, with or without children, living under the same roof that pool resources for monthly expenses. Persons may or may not be related. Children if Full Time Students over 18 may be used if still claiming on annual income taxes.

List Below the Full Name of members in the household and their Date of Birth

1._____ 3._____ 5._____

2._____ 4._____ 6._____

Documentation Required for Sliding Fee: These are due within 30days of Application or Placed Over Income

1. **Pay Stubs (Household's pay stubs for most recent 4 weeks)**
2. **Employer Letter (If paid in Cash)**
3. **Unemployment Benefit Summary Letter**
4. **Copy of Tax Records, Bank Statements, Self-Declaration Form**
5. **Other (Veterans, Social Security, Pension Benefits, Child/Alimony, Workman's Comp)**
6. **No Income - Provide a Notarized letter from person you know (not related) verifying you have no income and stating your living arrangements (food/shelter)**
7. **Food Stamp or Medicaid Eligibility Letter**
8. **Proof of Identity (Government Issue ID, Current DL, School ID, Birth Certificate)**

I Certify that my total Household income is $_____/Monthly or $_____/Yearly

INTAKE ACKNOWLEDGEMENTS

I have answered all questions truthfully, completely and to the best of my ability; including dollar amounts. I understand that failure to do so may result in denial of eligibility to receive services. I agree that Heart of Florida Health Center may verify this information through the use of a third party vendor. The facility, its employees, officers and practitioners are hereby released from any legal responsibility or liability for disclosures as indicated and authorized herein.

Signature:_____Date:_____

Office Use Only

☐Pay Stub ☐Copy of Taxes ☐Notarized Letter ☐Employer Letter ☐Medicaid Eligibility Letter ☐Other (Social Security/Pension ☐Unemployment Benefit Letter ☐Other Notarized Letters ☐Child/Alimony ☐Workman's Comp ☐Other Income ☐Bank Statements ☐Self-Declaration Form

Effective Date _____Renewal Date_____ SFS A-B-C-D-E-OI Approved by_____ Date_____

HEART OF FLORIDA HEALTH CENTER

2553 E. Silver Springs Blvd
Ocala, FL 34470
(352) 877-7180
(352) 433-2870 (Fax)

PHARMACY PATIENT INTAKE FORM

Welcome to our Pharmacy! Please complete this form so that we can ensure that your pharmacy file is current. Thank you!

*****Please provide a copy of your current prescription insurance card*****

First Name **Last Name** **M☐** **F☐** **DOB** **SSN**

Home Address **State** **Zip Code**

(_____)_____ **yes** **no**
Cell Phone **Phone Company** **Would you like to receive text messages when your prescription is ready for pick up? Please circle one.**

Would you prefer a NON-safety (easy open) cap for your medications? Yes☐ No ☐

I acknowledge receipt of Heart of Florida's Notice of Privacy Practices with my signature below.

Signature **Date**

Office Use Only:

Sliding Scale **Expiration Date**

Heart of Florida Health Center
352.732.6599

Name of Minor Child_____ Date of Birth _____

Name of Parent/Legal Guardian _____

Minor Authorization for Treatment

I give consent for Heart of Florida Health Center to examine and provide necessary treatment to the above-named minor child, including but not limited to: Screenings, diagnostic tests, prescription medications, and referrals to specialists or other health care providers. This consent applies to (initial all that apply):

_____ Medical services & treatment

_____ Dental services & treatment

_____ Behavioral health services & treatment

_____ I acknowledge that by filling prescriptions or requesting medication refills, I am consenting to the prescribing of the medication or treatment as deemed medically necessary by the ordering provider.

_____ I agree that HFHC may provide treatment or services with my verbal consent, in compliance with applicable law and HFHC policies.

I authorize the following relatives to bring the minor child to appointments **and to consent** to treatment or services in my absence, as permitted by Florida statutes 743.0645 (2)(a).

_____/_____
Name Relationship to child

_____/_____
Name Relationship to child

The following relatives are **NOT** authorized to consent to services for the minor child in my absence.

_____/_____
Name Relationship to child

_____/_____
Name Relationship to child

This consent is valid for one year from date signed, or _____ (*please specify if other*).
I understand that I may revoke this consent at any time by providing written notice to HFHC. Revocation will not affect any action taken in reliance on this authorization prior to receiving written notice of revocation.

Signature MUST be notarized if not signed in the presence of HFHC staff

Signature of Parent/Legal Guardian _____Date _____

Witness Signature_____Date_____

Witness Name (printed)_____