Patient Registration Form

This form is for new patients or patients that have not been seen by a provider in more than two years. You will need to complete this form in its entirety before your first appointment.

DESIGNATION OF HEALTH CARE SURROGATE FOR A MINOR

Determine who will have access to information concerning medical care, as well as who can bring the patient in for treatment.

I/We _____ and _____ the [ ] natural guardian(s) as defined in s. 744.301(1), Florida Statutes; [ ] legal custodian(s); [ ] legal guardian(s) of the following minor:

_____ _____

Name of Child Date of Birth

pursuant to s. 765.2035, Florida Statutes, designate the following person to act as my/our surrogate for health care decisions for such minor(s), if I/we am/are not able or reasonably available to provide consent for medical, dental and/or behavioral health treatment and surgical and diagnostic procedures:

_____ _____ _____

Name Address Telephone

If my/our designated health care surrogate for a minor is not willing, able, or reasonably available to perform his or her duties, I/we designate the following person as my/our alternate health care surrogate for a minor:

_____ _____ _____

Name Address Telephone

I /We, authorize and request Heart of Florida Health Centers Inc. to follow the instructions of my/our surrogate or alternate surrogate at any time and under any circumstances whatsoever, with regard to medical treatment which may include prescribing medicinal drugs and surgical and diagnostic procedures for a minor, provided the medical care and treatment of any minor is on the advice of a licensed clinician.

I/We fully understand that this designation will permit my/our designee to make health care decisions for a minor and to provide, withhold, or withdraw consent on my/our behalf, to apply for public benefits to defray the cost of health care, and to authorize the admission or transfer of a minor to or from a health care facility for medical or dental treatment. As these individuals will be acting on my behalf, I also agree to hold Heart of Florida Health Centers Inc. harmless (will not pursue legal action) for decisions which have been made by the named individuals regarding my child's health care. I understand I can revoke this consent at any time.

Stepparents, grandparents, adult brother or sister, and adult aunt or uncle can bring and consent to the treatment of a minor without authorization from the parent or legal guardian/custodian. **Initialing below will prohibit these individuals from bringing the minor and consenting for treatment unless they are listed above or the minor's parent, legal guardian/custodian has been contacted and gives verbal authorization**. To authorize only those named above to bring the minor and consent for treatment, **INITIAL HERE:** _____

Print Name: _____ Relationship to Patient: Date:

Signature: _____ ☐ Self ☐ Legal Custodian ☐ Natural Guardian (Parent) ☐ Legal Guardian ___/___/_____

Witnesses

1. _____ Date

2. _____ Date

Patient Name: _____