HEART OF FLORIDA HEALTH CENTER

**Patient Registration Form**

## PATIENT INFORMATION

**Last Name:** _____ **Date of Birth** (MM/DD/YYYY): ____/____/_____
**First Name:** _____ **Sex:** ☐ Male ☐ Female
**Middle Name:** _____ **SSN:** _____

**Address:** _____ **Cell Phone:** (____) _____
**City:** _____ **Home Phone:** (____) _____
**State:** _____ **Work Phone:** (____) _____
**Zip Code:** _____ **Email Address:** _____
☐ I do not have an email address

**Responsible Party (If different from the patient - for minors or patients with a legal guardian)**
Name: _____
Relationship to Patient: _____
Phone Number: (____) _____
Is this person financially responsible for the patient? ☐ Yes ☐ No

**Emergency Contact**
Name: _____
Relationship to Patient: _____
Phone Number: (____) _____

**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐Other: _____

**Communication & Language:**
Preferred Language _____
Do you need an interpreter? ☐ Yes ☐ No
☐ I am hearing impaired and need sign language services

**Race:** ☐ White ☐ Black/African American ☐ Asian ☐ Native American ☐ Pacific Islander ☐ Other: _____ ☐ I choose not to disclose

**Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Mexican American/Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other: _____ ☐ I choose not to disclose

**Alternate Housing (if applicable):** ☐ Homeless (outdoors/street) ☐ Homeless shelter ☐ Doubling up ☐ Transitional housing ☐ Permanent supportive housing

**Do you have a document that says what medical treatment you want if you cannot speak for yourself?** ***(This is called an Advance Directive. Examples: Living Will or POLST.)*** ☐ Yes ☐ No

**Pharmacy Preference:**
Heart of Florida Health Center operates a **discounted pharmacy program (340B)** for eligible patients. If you would like your prescriptions sent to an HFHC Pharmacy, please select one location

☐ **Silver Springs Blvd.** ☐ **Central (1st Avenue)**
☐ **Belleview** ☐ **Villages**

If you prefer to use a different pharmacy, please list the name and address below:
Pharmacy Name and Address: _____

## FINANCIAL AND INSURANCE INFORMATION

**This form is required for all patients. As a community health center, we use this information to help keep your care affordable.**

**Household Size** (Number of people in the household, as defined by tax dependency rules)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8+ (Other: _____)

**Household Income** (Select the range that best represents your household's total income)

☐ $0
☐ $1 – $25,000
☐ $25,001 – $50,000
☐ $50,001 – $75,000
☐ $75,001 – $100,000
☐ Over $100,000
☐ Prefer not to answer

| Insurance Information | **Medical Primary** | **Medical Secondary** | **Dental Primary** | **Dental Secondary** | **Vision** |
|---|---|---|---|---|---|
| Insurance Company | | | | | |
| Subscriber Name | | | | | |
| Subscriber Date of Birth | | | | | |
| Subscriber ID Number | | | | | |
| Group Number | | | | | |
| Relationship to Subscriber | | | | | |

☐ **I do not have insurance / Self-Pay**
☐ **Yes, I am interested in the Sliding Fee Discount Program**
☐ **No, I decline the Sliding Fee Discount Program at this time**

**Financial Information & Patient Responsibility**

Our health center provides care to all patients regardless of ability to pay. Fees are based on income and family size according to Federal Poverty Guidelines. Please read the information below

- Patients without insurance may qualify for our Sliding Fee Discount Program. Proof of income is required to determine eligibility. Failure to provide required income or insurance documentation may result in charges at the full fee rate.
- Patients who choose not to apply for the Sliding Fee Discount Program will be responsible for full fees for services received, including any amounts not covered by insurance.
- A minimum payment may be due at the time of your visit, based on your insurance status and sliding fee eligibility.
- Patients without proof of income may be charged a higher minimum fee.
- Patients with insurance are responsible for co-payments, deductibles, and non-covered services at the time of service.
- You are responsible for knowing your insurance benefits and for providing a current, valid insurance card at each visit.
- If your insurance does not cover a service, or if we are unable to bill your insurance, you may be responsible for the balance. Unpaid balances may result in billing statements and follow-up communication.
- Payment plans may be available for some services. Medically necessary care will not be denied due to inability to pay. Some optional or elective services require payment before treatment.

☐ ***I authorize HFHC to apply any future overpayments to any outstanding balance on my account instead of issuing a refund.***

I acknowledge that I have read and understand the financial policies described above. I understand that I am responsible for applicable fees, co-payments, deductibles, and non-covered services, and that providing accurate insurance and income information is my responsibility.

**Printed Name:** _____
**Relationship to Patient:** ☐ Self ☐ Parent ☐ Legal Guardian ☐ Legal Custodian
**Signature:** _____
**Date:** ___ / ___ / _____

## SLIDING FEE APPLICATION (ANNUAL SUBMISSION REQUIRED)

**Patient Name:** _____ **Date of Birth (MM/DD/YYYY):** ____/____/_____

### Household Information

Who lives in your household?
*(Include yourself, spouse/partner, and dependents you support.)*

**Total Household Size:** _____

### Household Income

What is your total household income?
(Include wages, benefits, and other income sources.)
*Examples: paychecks, Soc. Sec., disability, unemployment, or other income*

**Amount: $**_____

☐ **Weekly**
☐ **Bi-weekly**
☐ **Monthly**
☐ **Annually**

**Income Verification**

☐ **I have income AND I am providing proof today**. *(The final rate of the discount program will be applied.)*

☐ **I have income, but I cannot provide proof today.** *(The minimum rate will be applied for now. You must provide proof within 30 days, or you may be charged the full rate.)*

**Self-Declaration without Proof of Income:** I declare that my household has income, but I cannot present proof at this time. I confirm that the information written above is correct to the best of my knowledge. I understand that this declaration gives me temporary access to the Discount Program.

**Patient or guardian initials:** _____

☐ **My household income is $0**

**No-Income Declaration:** I certify that my household currently does **not receive income from any source.** Check what describes your situation:

- ☐ I am Unemployed
- ☐ Temporary or seasonal work
- ☐ I receive support from family or friends
- ☐ I receive support from an agency or program. Program name: _____
- ☐ Other: _____

**Patient or guardian initials:** _____

### Acknowledgments & Responsibilities

I understand that:

• Eligibility for the Sliding Fee Discount Program is based on household income and size and applies only to eligible services.
• Eligibility may change if my household income or size changes, and I am responsible for notifying Heart of Florida Health Center of any changes.

### Patient Attestation & Signature

I certify that the information provided on this application is **true and complete** to the best of my knowledge. I understand that providing false or incomplete information may result in **loss of eligibility** for the Sliding Fee Discount Program. I understand that this application must be **renewed annually**, or sooner if my financial situation changes.

**Patient / Responsible Party Signature:** _____
**Printed Name:** _____
**Relationship to Patient:** ☐ Self ☐ Parent ☐ Legal Guardian
**Date:** ___ / ___ / _____

**Staff Use Only**
Slide Assigned: ☐ A ☐ B ☐ C ☐ D ☐ E ☐ F
Docs Reviewed: ☐ Yes ☐ No
Effective Date: _____
Staff Initials: _____

## CONSENT FOR CARE & TREATMENT

I give my voluntary consent for Heart of Florida Health Center, Inc. (HFHC) to provide healthcare services to me (or the patient listed below).

- **Services Provided:** HFHC may provide medical, dental, nursing, and behavioral health services. This may include preventive care, examinations, diagnostic tests, immunizations, laboratory studies, X-rays or other imaging, medications, telemedicine visits, referrals, and other treatments my provider determines are appropriate. I may ask questions and refuse any treatment at any time.
- **No Guarantee:** I understand that no treatment or procedure is guaranteed to improve my condition. If HFHC is unable to treat my condition, I will be informed and referred to appropriate care when possible.
- **Exams, Records, and Care Team**: My provider may perform X-rays, imaging, photographs, diagnostic tests, and necessary procedures as part of my care. My medical record and related materials are the property of HFHC; copies may be provided upon request as allowed by law. My care may involve trained assistants, students, residents, or other healthcare trainees under the supervision of a licensed provider.
- **Telemedicine:** Telemedicine uses electronic communication to provide care remotely by video or other electronic means. I understand there may be limitations, including technical difficulties, reduced ability to perform a full physical examination, and potential privacy risks, although safeguards are in place. I may decline telemedicine and request an in-person visit when available.
- **Use of Technology and Artificial Intelligence (AI) Tools**: HFHC may use technology tools to support clinical documentation, care planning, medical record review, and quality improvement. This may include artificial intelligence (AI)–assisted technology. These tools support, but do not replace, licensed healthcare providers. All final clinical decisions are made by a licensed provider. AI tools do not independently diagnose, prescribe, or determine treatment
- **Communication:** HFHC may contact me by phone, text message, email, patient portal, or other electronic means regarding my care, appointments, results, and related matters. Some communications may be sent using automated systems. I may opt out of certain communications at any time. Standard messaging and data rates may apply.
- **Health Information:** HFHC may use and disclose my health information as permitted by law for treatment, payment, and healthcare operations. This includes billing, care coordination, required public health or school reporting (such as immunizations), and secure information exchange with other healthcare systems. Behavioral health information will be kept confidential and disclosed only as permitted by law. HFHC may use de-identified information for quality improvement, training, research, and system improvement as permitted by law.

**Authorization to Share My Health Information**

I authorize HFHC to share my health information with the individuals listed below. This may include information about appointments, treatments, test results, and billing.

| Name of Authorized Person | Phone Number | Relationship |
|---|---|---|
| | | |
| | | |
| | | |

**Acknowledgment**

I acknowledge that I have been provided access to, or offered information regarding, Heart of Florida Health Center's patient rights and responsibilities, notice of privacy practices, financial and billing policies (including payment expectations and the Sliding Fee Discount Program), advance directive information, and how care is provided at the health center. I also acknowledge that I have read and understand this consent. I have had the opportunity to ask questions, and all questions have been answered to my satisfaction. This consent remains in effect unless revoked by me in writing.

**Printed Name:** _____

**Relationship to Patient:** ☐ Self ☐ Parent ☐ Legal Guardian ☐ Legal Custodian

**Signature:** _____

**Date:** ___ / ___ / _____