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: ___ / ___ / _____

MINOR CARE AUTHORIZATION

Permission for Another Adult to Assist With My Child's Care

I/We, _____ and _____, am/are the
☐ Parent(s) (Natural Guardian[s]) ☐ Legal Custodian(s) ☐ Legal Guardian(s) of:

Child's Name: _____
Date of Birth: ___ / ___ / ____
Under Florida law (s. 765.2035 and s. 744.301(1)), I/We authorize the individual(s) listed below to make medical, dental, and behavioral health decisions for my/our child if I/we are not available.

Please list all adults you want authorized to bring the child for care or make health care decisions (for example: parents, grandparents, or other caregivers).

Primary Authorized Individual(s)

Name	Address	Phone Number

Backup Authorized Individual(s)

Name	Address	Phone Number

What This Authorization Allows
By signing below, I/We understand and agree that:

- Heart of Florida Health Centers (HFHC) may follow the instructions of the authorized individual(s) listed above regarding my/our child's care.
- These individuals may consent to medical, dental, and behavioral health treatment, medications, diagnostic tests, and procedures.
- These individuals may apply for benefits to assist with payment for care and approve transfers or referrals if needed.
- HFHC is not responsible for decisions made by the authorized individual(s).
- This authorization may be revoked at any time by providing written notice to HFHC.

Bringing a Child for Care (Florida Law)
Under Florida law, certain family members (such as stepparents, grandparents, adult siblings, aunts, or uncles) may bring a child for care without prior written authorization.

☐ **I do NOT want this provision to apply.** Only the individual(s) listed above may bring my child for care unless I/we provide separate authorization.

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