Family Health Centers
OF SOUTHWEST FLORIDA, INC.

TODAY'S DATE **PLEASE PRINT**

PATIENT REGISTRATION FORM

Social Security No.:	First Name:	Middle:	Last:

Sex: ☐ M ☐ F | Birth date: | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Race: ☐ Asian ☐ Black/African American ☐ White ☐ American Ind./Alaska Nat. ☐ Native Hawaiian ☐ Pacific Islander ☐ Haitian Black ☐ Haitian White ☐ More Than One Race

Ethnicity: ☐ Hispanic or Latino ☐ Non – Hispanic | Preferred Language:

Employed: ☐ Yes ☐ No | Employer:

Street Address: | Home Phone:

City: State: ZIP Code: | Cell Phone:

Email: | Work Phone:

Referral Source: ☐ Referring Provider ☐ Ins. Company ☐ Flyer/Mailing ☐ Walk-In ☐ Hospital ☐ School ☐ Yellow Pages ☐ Newspaper ☐ Health Fair ☐ Family/Friend ☐ Other/Unknown ☐ Outreach Event

Are you a Veteran? ☐ Yes ☐ No

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Ins. Carrier:	Pt's Relationship to Subscriber:	Grp. No.:	Policy No.:

EMERGENCY CONTACT

☐ Parent ☐ Spouse ☐ Child ☐ Other Sex: ☐ M ☐ F

First Name:	Middle:	Last:

Preferred Language:	Home Phone:	Cell Phone:	Work Phone:

PARENT/GUARDIAN INFORMATION

☐ Parent ☐ Spouse ☐ Child ☐ Other Sex: ☐ M ☐ F

First Name:	Middle:	Last:

Social Security No.:	Birth date:	Preferred Language:	Home Phone:	Cell Phone:	Work Phone:

PREFERRED PHARMACY

Pharmacy Name:	Phone:	Fax:

Street Address or Cross Street:	City:	State:	Zip Code:

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FHCSWF FINANCIAL CLASSIFICATION WORKSHEET

Family Health Centers of Southwest Florida, Inc. (FHCSWF) needs to gather your household income information. By sharing this, you will help us to continue to provide quality healthcare to all of our patients. If you do not have insurance coverage, your financial information will assist us in determining if your family is eligible for discounted fees.

Annual Household Income* ☐ *Self Declaration* ☐ *Proof Provided*

SOURCE	AMOUNT	WEEKLY	BI-WEEKLY	MONTHLY	ANNUAL
Gross wages & salaries (Self/Guarantor)		☐	☐	☐	☐
Gross wages & salaries (Spouse)		☐	☐	☐	☐
Social Security (Self/Spouse/Children)		☐	☐	☐	☐
SSI (Supplemental Security)		☐	☐	☐	☐
Pension, Retirement, Veteran's benefits, etc.		☐	☐	☐	☐
Unemployment compensation		☐	☐	☐	☐
Public Assistance/Food Stamps		☐	☐	☐	☐
Disability, Workers Compensation		☐	☐	☐	☐
Alimony, child support		☐	☐	☐	☐
Other Income (Rent, interest, dividend, etc.)		☐	☐	☐	☐
Total Income:		**Household includes the guarantor, spouse, children or step-children 18 yrs & under, and handicapped children (no age limit)*			
Total Number in Household*:					

FHCSWF reserves the right to verify your tax return and/or wage statement for previous pay periods upon request. Your financial classification status will be updated on an annual basis. Please notify us if there are changes in your income status prior to the annual update.

I hereby certify that the above income and family information is true and correct to the best of my knowledge. I understand that if I have knowingly given false information, I am liable for prosecution under State and/or Federal law.

Name (Print): Date:

Signature:

PATIENTS REQUESTING A SLIDING FEE SCALE DISCOUNT MUST READ AND SIGN THE FOLLOWING:

I have been informed and understand that if I do not supply proof of income at my next visit, I will not be eligible for discounted fees and will be expected to pay the full fee at time of service.

Name (Print): Date:

Signature:

Migrant / Seasonal / Other Determination

Answer the following questions regarding You or Guarantor's employment with the past 24 months:	**Yes**	**No**
1. Worked/Working in the fields, tilling soil, or picking fruits, vegetables, flowers, sugar cane, etc.?		
2. Worked/Working in a packinghouse or transporting any items listed in #1?		
3. Performed/Performing landscaping or tree farming?		
4. Worked/Working on a worm farm, shrimp boat, or gathering of other seafood?		
5. Have you/guarantor moved outside the country/state to perform your/their job anytime during the year?		
6. Do you or the guarantor stay at one permanent address to perform your/their job throughout the year?		

OFFICE USE ONLY

Proof of income verified: ☐ YES ☐ NO Recorded by: Date:

SFS: ☐ A ☐ B ☐ C ☐ D Expiration Date:

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GENERAL CONSENT FOR TREATMENT AND BILLING	
1.	I, the undersigned, give permission for myself or minor child, as indicated above, to undergo all necessary tests, examinations, treatments, or other procedures required by the medical or dental staff for Family Health Centers of Southwest Florida, Inc. (FHCSWF) to diagnose and/or treat illness(es).
2.	I realize that the practice of medicine, surgery, and dentistry is not an exact science, and I acknowledge that no guarantees have been made to me as a result of treatments or examinations by FHCSWF.
3.	I consent to the release of my medical and dental information by FHCSWF and/or authorized institutions or agencies accepting the patient for medical, dental, or institutional care. I consent to the release of medical and dental information to patient's insurer. I give permission to release data (medical, dental, and personal) to such government agencies as is required of FHCSWF.
4.	I hereby authorize payment to FHCSWF of benefits due to me in my pending claim and/or MAJOR MEDICAL BENEFITS otherwise payable to me, but not to exceed the health center and/or physician's or dentist's regular charges for this period of treatment.

FHCSWF PATIENT BILL OF RIGHTS AND RESPONSIBILITIES	
1.	I acknowledge that I have received a copy of the FHCSWF Patient Bill of Rights and Responsibilities, which is a mutual agreement between me and FHCSWF

HIPAA – NOTICE OF FHCSWF PRIVACY PRACTICE

1. I acknowledge that I have received a copy of the Notice of Privacy Practices that explains the commitment of FHCSWF to protecting my personal health information in compliance with the law.
I do hereby authorize the unrestricted release of my personal health information to the following individuals:

NAME:	RELATIONSHIP *(e.g. – Mother, Sister, Spouse, ect.)*
1.	
2.	
3.	

ADVANCE DIRECTIVES – RIGHT TO DECIDE – END OF LIFE DECISIONS

You cannot remove all uncertainty about your future healthcare needs but, by having Advanced Directive, you can have the peace of mind that comes from making your wishes known in advance.

1. *Declaration to Decline Life – Prolonging Procedures (Living Will)*
☐ I have a Living Will – Please make a copy and FHCSWF will place in your Medical Record.
☐ I do NOT have a Living Will.

2. *Health Care Surrogate – This is a person whom you trust and have chosen to speak to your doctors for you when you are unable to do so.*
☐ I have a designated Health Care Surrogate who is _____ and can be reached at _____.
☐ I do NOT have a designated Health Care Surrogate.

3. *Durable Power of Attorney – A document which you sign to authorize another person to act as your agent and make Health Care decisions for you.*
☐ I have an appointed Durable Power of Attorney who is _____ and authorized to make Health Care decisions for me.
☐ I have NOT appointed a Durable Power of Attorney for my Health Care decisions.

VACCINE FOR CHILDREN ELIGIBILITY
(If any answers are marked as YES, child is eligible for Vaccines for Children)

ELIGIBILITY REQUIREMENT	YES	NO	DATE
Medicaid Eligible			
No Health Insurance			
American Indian or Alaskan			
Health Insurance does NOT pay for vaccines			

Signature of Patient/Responsible Party/Guarantor:_____ **Date:**_____

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	YES	NO
1. Are you generally in good health at this time?		
2. Are you under the care of a medical doctor at this time? If **yes**, when was your last visit? _____		
3. Have you been hospitalized in the last two years?		
4. Have you ever had any serious accident involving a head injury? If **yes**, what kind of injury and when? _____		
5. Do you smoke or use any tobacco product?		
6. Do you have any drugs allergies? If **yes**, please list: _____		
7. Do you have a known allergy to latex based products?		
8. Has your medical doctor ever told you to take medication for a heart murmur prior to any Dental Treatment? If **yes**, please list*:* _____		
9. Have you ever been diagnosed with any of the following: Circle if **YES** Heart Murmur — High Blood Pressure — Respiratory Disease Diabetes — Rheumatic Fever — Rheumatism/Arthritis/Osteoarthritis Cancer — Muscular Diseases — Skin Disorder (eczema, rosacia) Tumor/Growth — Blood Diseases — Liver Disease Kidney Disease — Jaundice or Hepatitis — Stomach/Intestinal Disease Venereal Disease — Heart Disease — Psychiatric/Behavioral Problems Other:		
10. Do you have a history of, or, are currently being treated for any of the following: (Please circle all that apply) – Artificial heart valves – Previous infective endocarditic diagnosis – Congenital Heart Disease Please Describe: _____ – Join Replacement – Which joint(s) and when were procedures done? _____ – Transplants		
11. Have you had any abnormal bleeding during past surgical procedures of dental extractions?		
12. Are you taking any drugs or medications? Please list or attach copy of list:		
13. Have you had any wounds, which healed slowly?		
14. Are your pregnant? If yes, how many weeks? _____ Have there been any complications? _____		

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	YES	NO
15. Do you have any history of fainting? If yes, what was the cause?		
16. Have you ever been or are currently being treated for cancer with chemotherapy or radiation? (circle one or both) If yes to chemotherapy; When was your last cycle? _____ When is your next cycle? _____ Do you currently have a port (Infusport / Hickmann Venous)? If yes to radiation, when was the last therapy given? _____ If you are scheduled for therapy, when will you start? _____		
17. Have you ever had a blood transfusion? If yes, what year?		
18. Are you HIV positive? CD4+ count _____		
19. Do you have AIDS?		
20. Have you ever had surgery? If yes, please list them with dates:		

Patient/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

HISTORY UPDATES

Patient/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

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Family Health Centers
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PATIENT'S BILL OF RESPONSIBILITIES

We, FAMILY HEALTH CENTERS OF SOUTHWEST FLORIDA, INC., are pleased to be your provider of health care and related services. As our patient, you have "RESPONSIBILITIES" that will help us serve you more promptly and efficiently. This is a mutual partnership established between you, our patient (parent or custodian of our patient) and us, the professional staff of Family Health Centers of Southwest Florida. This agreement is called the PATIENT'S BILL OF RESPONSIBILITIES. We are giving you a copy of this as we begin your care with us, as an acknowledgement of our mutual agreement. Another copy will be maintained in your medical chart. Thank you for the opportunity to serve you.

As a Patient of Family Health Centers you are RESPONSIBLE for:

1. Giving accurate and complete health information concerning your past illnesses, hospitalizations, medications, allergies and other pertinent information such as your past physicians/medical providers.
2. Reporting any unexpected changes in your condition.
3. Participating in the development and updates of your personal health care regime (or that of your child/dependent) and requesting further information concerning anything you do not understand.
4. Following your health care regime.
5. Your actions, if you refuse treatment or do not follow the recommendations of Family Health Centers for your health care.
6. Keeping appointments for any scheduled service at Family Health Centers or First Choice Pediatrics or its referrals including clinical and financial referrals
7. Notifying us if you are unable to keep your appointment for any reason.
8. Providing Family Health Centers with accurate and complete financial information and for paying any amounts which are required for your financial classification.
9. Providing Family Health Centers with any name, address or telephone number changes.
10. Assisting us in maintaining a safe and clean environment by following the Center's rules for patient care and conduct.
11. Working with your physician/provider to develop a pain management plan and assist in assessment of your pain to assure that effective pain relief becomes an important part of your treatment.
12. Treating Family Health Center's staff with courtesy and respect.
13. **YOUR CHILDREN**. Do not leave them unattended or allow them to act in a manner that may cause harm to themselves or others.

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PATIENT'S BILL OF RIGHTS

We, FAMILY HEALTH CENTERS OF SOUTHWEST FLORIDA, INC., are pleased to be your provider of health care and related services. As our patient, you have "RIGHTS", which will help us serve you more promptly and efficiently. This is a mutual partnership established between you, our patient (parent or custodian of our patient) and us, the professional staff of Family Health Centers of Southwest Florida. This agreement is call the PATIENT'S BILL OF RIGHTS. We are giving you a copy of this as we begin your care with us, as an acknowledgement of our mutual agreement. Another copy will be maintained in your medical chart. Thank you for the opportunity to serve you.

As a patient of Family Health Centers you have the RIGHT to:

1. Be treated with courtesy, respect, consideration, dignity, privacy and confidentiality; regardless of your race, creed, color, religion, sex, national origin, sexual preference, handicap or age; by all who provide quality health care and other services to you at Family Health Centers.
2. Be given information concerning the available services of Family Health Centers including, any patient support or after hours services we have available and information on access to emergency services.
3. Prompt and reasonable response to your questions and requests.
4. Choose your health care physicians/medical providers and know who is responsible for your care by being given proper identification by name and title of everyone who provides health care or other related services to you.
5. Be given information on our policies and charges for services including your eligibility for third party reimbursement, acceptance of assignment for private insurance plans, Medicaid and Medicare, and any other financial assistance known to us.
6. Be given complete and current information concerning your diagnosis, treatment alternatives, risks, and prognosis (as required by your physician's legal duty to disclose) in terms and language you can reasonably understand.
7. Refuse treatment within the confines of the law.
8. Refuse to participate in experimental research.
9. Voice grievances and/or suggest changes in health care services and staff without being threatened, restrained, or discriminated against. If your concerns cannot be resolved through the organization, you are encouraged by the Family Health Centers of Southwest Florida to contact the Joint Commission. You may contact the joint Commission's Office of Quality Monitoring to report any concerns or register complaints about Family Health Centers of Southwest Florida by either calling 1/800-994-6610 or e-mailing complaint@jcaho.org.
10. Participate in the development of your health care regime to meet your personal health care needs, with periodic assessments/updates which will be reviewed with you.
11. Receive an appointment from Family Health Centers regarding your request for health care and/or other services.
12. Be given complete and current information by Family Health Centers so you will be able to give informed consent for your treatment prior to the start of any treatment.
13. Review your clinical records at your request, but within the policies of the Family Health Centers.
14. Be given information regarding anticipated transfer of your health care to another health care facility and/or termination of health care services to you.
15. Be given information concerning the consequences of refusing treatment or not complying with therapy.
16. Receive an itemized bill and explanation of charges.
17. Know the rules which apply to your conduct.
18. Appropriate assessment and management of your pain.

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STATEMENT OF PATIENT PRIVACY NOTICE

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

(Effective Date: April 14, 2003)

- Your protected healthcare information may be released to other healthcare professionals within Family Health Centers of Southwest Florida's staff, other healthcare providers by referral, and other entities covered by these privacy provisions for the purpose of providing you with quality healthcare.
- Your protected healthcare information may be released to your insurance provider for the purpose of Family Health Centers receiving payment for providing you with needed healthcare services.
- Your protected healthcare information may be released in connection with Family Health Centers' healthcare operations to include internal evaluation of the quality of services provided to you, and to allow outside agencies to review, certify or license the healthcare services provided to you.
- Your protected healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your protected healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your protected healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Your protected healthcare information may be released only after receiving written authorization from you. You have the right to restrict the release of your protected healthcare information. However, Family Health Centers may chose to refuse your restriction request if it is in conflict with providing you with quality healthcare or in the event of an emergency situation
- You may revoke your permission to release protected healthcare information at any time. It must be done in writing and contain an effective date and a list of the specific health information to be protected from release. Family Health Centers is NOT required to agree to your request.
- You may be contacted by Family Health Centers by phone message or mail to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.
- You may be contacted by Family Health Centers for the purposes of raising funds to support the organization's operations.
- You have the right to receive confidential communication about your health status
- As part of the Family Health Center billing system, all members of your immediate family will be billed under one master account number. You will receive one monthly billing statement for the whole family ('Family Billing'). A separate account for each member within the family may be setup by the Family Health Centers of Southwest Florida's registration department at the written request of the patient
- You have the right to review and photocopy any/all portions of your protected healthcare information. Family Health Centers has the right to assess a reasonable fee for the photocopying of such information.
- You have the right to request changes to your protected healthcare information. Your request must be made in writing and explain why the information should be amended. Family Health

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Centers can deny the requested change and if so, provide you with a written explanation for the denial.

- You have the right to know who has accessed your protected healthcare information and for what purpose. Your request for disclosure of who as accessed your protected healthcare information must be done in writing to the Patient Privacy Officer listed below.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.
- Family Health Centers is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices that protect protected healthcare information.
- Family Health Centers will abide by the terms of this notice, and reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Patients will receive a copy of any changes to this notice upon their next visit to Family Health Centers.
- You have the right to complain to Family Health Centers if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your written complaint to:

Patient Privacy Officer
Family Health Centers of Southwest Florida
P.O. Box 1357
Fort Myers, Florida 33902

- All complaints will be investigated. No personal issue will be raised for filing a complaint.
- For further information about this Privacy Notice, please contact:

Family Health Centers Privacy Contact Officer
Telephone: (239) 278-3600/ Fax: (239) 278-3203

- This notice is effective as of the date printed at the top of this document. This date must not be earlier than the date on which the notice is printed or published.

Family Health Centers of Southwest Florida, Inc. is a Federally Qualified Health Center recognized by the Joint Commission on Accreditation of Healthcare Organizations