Welcome to our practice and thank you for choosing CAN Community Health.

MISSION

Our mission at CAN Community Health is to provide a continuum of medical, social and education services essential to the health and well-being of those living with HIV/AIDs, Hepatitis C, sexually transmitted disease, other diseases and to enhance public awareness

Before the day of your first appointment, please ensure you have signed and returned the new patient registration packet. If you prefer to send it by email, please send to careconnectionteam@cancommunityhealth.org. If you have questions about the packet please contact our Care Connection Team at 941-366-0134, option 3.

On the day of your first appointment:

- Please arrive 15 minutes prior to your scheduled appointment time. This will allow us to complete the registration process in a timely manner.
- Bring your insurance card and a picture I.D.
- Bring Medical Records from your referring physician
- Bring a current list of your medications including dosage.

REFERRALS

If your insurance company requires you to have a referral, please contact your Primary Care Physician and secure one prior to your appointment. If the referral is not issued before your appointment time, it may be necessary to reschedule.

COPAYMENTS/DEDUCTIBLES

If your insurance requires a co-payment, or if you have a deductible, the payment will be collected before services are rendered. Financial Assistance available for those who qualify.

For your convenience, we accept cash, checks, MasterCard, Visa, Discover and American Express cards.

NO SHOW POLICY

If you need to cancel your appointment and do not call to cancel 24 hours in advance, you may be charged a $35.00 no-show fee- $5.00 for Nurse or Lab Visits.

We look forward to participating in your health care needs.

Sincerely,

The Staff at CAN Community Health

Your Information.
Your Rights.
Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. • We will say "yes" unless a law requires us to share.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on the back page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

Our Uses and Disclosures

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

This notice applies to all CAN Community Health, Inc. clinics.

CAN Community Health, Inc.
1231 N. Tuttle Ave.
Sarasota, FL 34237

cancommunityhealth.org

Patrick Forand, MPH
Risk Manager
pforand@cancommunityhealth.org
941-366-0134

CAN COMMUNITY HEALTH

PATIENT REGISTRATION FORM

Today's Date:	S.S. #:	Primary Care Provider:

Patient Information

Title:	First name:	Middle:	Last:	Birth date:

Sex at birth:
☐ Male ☐ Female

Sexual Orientation:

Gender:
☐ Female ☐ Female-to-Male/Transgender male/Trans man ☐ Gender queer; neither exclusively male nor female
☐ Male ☐ Male-to-Female/Transgender female/Trans woman ☐ Refused to report
☐ Other, Please Specify: _____

Race:	Ethnicity:	Marital status:	How would you like to be reminded about scheduled appointments? ☐ Home Phone ☐ Cell phone ☐ Text ☐ Email

Address:

Home Phone:

Work Phone:

Would you like more information about our patient portal?
☐ YES ☐ NO

(if YES, please enter email below)

Cell phone:

Email:

Other family members that are seen here:

INSURANCE INFORMATION (please give your insurance card to the receptionist)

Person responsible for the bill:	Birth date:	Address (if different)	Home phone:

Is the person a patient here?	Is this patient covered by insurance:

Occupation:	Employer:	Employer address:	Employer phone:

Primary insurance:	Member ID:	Group #:

Guarantor's name:	Guarantor's S.S. #:	Birth date:	Patient's relationship to guarantor:

Secondary insurance (if applicable):	Member ID:	Group #:

Guarantor's name:	Patient's relationship to guarantor:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address):	Relationship to patient:	Home Phone:	Cell Phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to CAN Community Health. I understand that I am financially responsible for any balance. I also authorize CAN Community Health or my insurance company to release any information required to process my claims.

_____ _____
Patient/Guardian Signature Date

Name_____
ID# _____
Date of Birth_____/_____/_____

CAN COMMUNITY HEALTH

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

Name: _____ **MIP#** _____

Facility/Site/Program: _____

I have received a copy of the CAN Community Health Privacy Practices, effective 09/01/2016.

Signature: _____ **Date:** _____
Individual or Representative with legal authority to make health care decisions

If signed by a Representative:

Print Name: _____ Role: _____
(Parent, guardian, etc.)
Witness: _____ Date: _____

If the individual has a representative with legal authority to make health care decisions on the individual's behalf, the notice must be given to and acknowledgment obtained from the representative. ***If the individual or representative did not sign above, staff must document when and how the notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.***

Notice of Privacy Practices given to the individual on: _____
Date

___ Face to face meeting
___ Mailing
___ Email
___ Other _____-

Reason Individual or Representative did not sign this form:

___ Individual or Representative chose not to sign
___ Individual or Representative did not respond after more than **one** attempt
___ Email receipt verification
___ Other _____

Good Faith Efforts: The following good faith efforts were made to obtain the individual's or Representative signature. Please document with detail (e.g., date(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature. More than **one** attempt must have been made.

___ Face to face presentation(s) _____
___ Telephone contact(s) _____
___ Mailing(s) _____
___ Email _____
___ Other _____

Staff Signature: _____ **Date**: _____

Print Name: _____ **Date:** _____

Name_____
ID# _____
Date of Birth_____/_____/_____

PATIENT INFORMATION RELEASE

USE ONE RELEASE PER PERSON/FACILITY

I, _____, give permission to all staff at CAN Community Health to speak with_____

(Relationship and Contact Number – Please Print)

regarding all aspects of my care, including, but not limited to, making and canceling appointments, billing and insurance matters, housing, and all issues relating to my medical and dental care.

All information hereby authorized by me to be obtained by CAN Community Health will be held strictly confidential and cannot be released by the recipient without my written consent.
I understand that this authorization will remain in effect until revoked by me in writing.

_____ _____
Date Client *(sign)*

_____ _____
Date Client *(print name)*

_____ _____
Date Representative/Guardian *(sign)*

_____ _____
Date Representative/Guardian *(print name & relationship)*

_____ _____
Date Witness *(sign and print name)*

Withdrawal Of Consent

_____ _____
Date consent revoked Client/Representative/Guardian Signature

_____ _____
Date Witness *(sign and print name)*

Name_____
ID# _____
Date of Birth_____/_____/_____

Revised 11/22/2017

INITIATION OF SERVICES

PART I: CLIENT-PROVIDER RELATIONSHIP CONSENT

Client Name: _____

Name of Agency: _ _____

Agency Address: _____

I consent to entering into a client-provider relationship. I authorize CAN Community Health and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical office visits including obtaining medical history, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue the relationship at any time.

PART II: DISCLOSURE OF INFORMATION CONSENT (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my medical information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations

PART III: MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my medical information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above named agency and authorize it to submit a claim to Medicare for payment.

PART IV: ASSIGNMENT OF BENEFITS (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V: MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS

_____ _____ _____

Client/Representative Signature | Self or Representative's Relationship to Client | Date

_____

Client/Representative Name-Print

_____ _____

Witness | Date

PART VI: WITHDRAWAL OF CONSENT

I, _____ WITHDRAW THIS CONSENT, effective _____

Client/Representative Signature | Date

_____ _____

Witness | Date

Client Name: _____

ID#: _____

DOB: _____

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

Patient's Name: _____ DOB: _____ Patient ID: _____

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: _____ Phone #: _____

Address: _____ Fax #: _____

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: _____ Phone #: _____

Address: _____ Fax #: _____

Other method of communication: _____

I SPECIFICALLY AUTHORIZE RELEASE OF INFORMATION REALTING TO: (initial selection)

___ General Medical Records ___ History & Physical Results ___Family Planning ___ Sexually Transmitted Diseases

___Progress Notes ___Mental Health (other than psychotherapy notes __HIV/AIDS related information and treatment

___ All of my health information that the providers has in his or her possession, including information relating to any medical history, mental (excluding psychotherapy notes), or physical condition and any treatment received by me.

___ Psychotherapy notes: If psychotherapy notes is selected, no other item may be selected. A separate form must be completed. Psychotherapy notes use or disclosure is at the discretion of the author of the note.

___Diagnostic test reports (specify type of test(s): _____

___ Other (specify) : _____

__HIV/AIDS related information may be sent via fax

PURPOSE OF DISCLOSURE:

___Continuity of Care ___ Personal use ___ Other (specify): _____

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify and expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

Notice to Patient:

By signing this form, you grant us consent to disclose your protected health care information to the individual(s) listed above. Our **Notice of Privacy Practices** provides more details on uses and disclosures of your protected health information for treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information. You understand that the above information may be redisclosed by the recipient and may not be protected by federal privacy laws or regulations. You understand that completing this authorization form is voluntary and that treatment will not be denied if you refuse to sign this form.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You are entitled to a copy of this **Consent Form** after you have signed it.

_____ _____

Client/Representative signature Date

_____ _____

Printed name Representative's relationship to client

_____ _____

Witness (optional) Date

CONSENT FOR E-MAIL/TEXT COMMUNICATION

Unencrypted e-mail and texting is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such e-mail or text may be misdirected, disclosed to or intercepted by unauthorized third parties. You will not hold CAN Community Health liable if others access your e-mail or text messages from your computer, phone or another mobile device.

By signing below, you may consent to receive e-mail and/or text messages from us regarding your treatment. E-mail and texts sent to you may be included as a part of your medical record. We will use the minimum necessary amount of protected health information in any communication. Our first e-mail or text to you will verify the e-mail address or mobile phone number you provided.

Please initial next to your choice regarding e-mail or text communication:

_____ I consent to and accept the risk in receiving information via e-mail or text message. I understand I can withdraw my consent at any time.

_____ I consent only to receiving appointment reminders via e-mail or text message. I understand I can withdraw my consent at any time.

E-mail address: _____

Mobile phone number: (_____) _____

Mobile phone provider: _____

_____I do not consent to receiving any information via e-mail or text message.

_____I withdraw my consent to email/text communication. You can also withdraw consent by sending an email to CAN Community Health. This will be recorded in your medical record.

If I send an e-mail or text message to CAN Community Health, I will take that as permission to correspond via email. Our reply email will explain that emails are not secure and request that you sign this form the next time you are in our office. I understand that I can change my mind and provide consent later.

_____

Print Name and DOB

_____ _____

Signature Date

Name_____

ID# _____

Date of Birth_____/_____/_____

Revised 11/30/2017

NEW PATIENT INITIAL VISIT MEDICAL HISTORY FORM

Welcome to our clinic. Completing the following forms will allow us to personalize your care and assist us in providing you the quality care you deserve from your healthcare providers. Please complete all sections that apply to your particular needs as completely and accurately as possible. If you are uncertain of a specific date of an event, the approximate or "best guess" at the month and year are acceptable. Thank you for choosing us to provide your care and again, welcome to our clinic.

Today's Date:_____ New Patient_____ Returning Patient _____ If Yes, Last visit _____

Preferred Language: ☐ English ☐ Other_____ Would you like an interpreter ☐ Yes ☐ No
Idioma preferida *¿Te gustaría un intérprete?*

Demographic Information:

Date of Birth: _____ Best Contact Phone #: ☐ Home: _____ ☐ Cell: _____

Patient Name: _____

Local Address: _____ City: _____State: _____Zip: _____

Alternate Address: _____ City: _____State: _____Zip: _____

Emergency Contact: _____ Phone: _____Relation: _____

Reason for your visit today: ☐ Initial visit only ☐ Initial visit AND _____

_____

_____

Newly diagnosed with HIV? (circle one): Yes / No Date Diagnosed:_____

If not, previous HIV provider name/location: (complete release of information) _____

_____

_____

_____

If previous positive HIV Test, but no treatment, please list the location where the patient was tested and any location additional labs were obtained (complete release of information): _____

_____

_____

YOUR COMPLETE TREATMENT TEAM (PLEASE LIST ALL YOUR PHYSICAL/MENTAL HEALTH CARE PROVIDERS)

MD NAME	**SPECIALTY** (EX. GI, OB-GYN,PCP…)	**WHY** CONDITION THEY ARE TREATING	WHERE (CITY, STATE)

Name_____
ID# _____
Date of Birth_____/_____/_____

MEDICATIONS:

MY PREFERRED PHARMACY IS:_____ADDRESS/PHONE#_____

ALLERGIES: Are you allergic to medication(s), food, tape, iodine, latex or bee-stings? ___ None ___Yes

Please List Below:

Drug:	Reaction:	Other:	Reaction:
Drug:	Reaction:	Other:	Reaction:
Drug	Reaction	Other:	Reaction
Drug:	Reaction:	Other:	Reaction:

MEDICATIONS:

CURRENT MEDICATIONS Please include **DAILY** Vitamins/herbals and Over the Counter meds at end of list				
Drug Name:	Dose (Mg.;ml.;units)	How often?	**How long?** MM/Yr started	**If Not from This Clinic** the prescribing doctors name and specialty

****ADDITIONAL SPACES ARE PROVIDED AT END OF THE QUESTIONNAIRE IF NEEDED.**

MEDICAL HISTORY

IMMUNIZATION HISTORY

IMMUNIZATION/VACCINE	**YEAR**	**IMMUNIZATION/VACCINE**			**YEAR**
Flu vaccine within last year ___Yes ___ No ___Unknown I Would like to receive the **Flu Vaccine** today ___Yes ___ No		Hepatitis **A** Vaccine			
Adult Pneumovax __Yes __ No __ Unk (Yrs 1st & +5 or max 2 in a lifetime) I Would like to receive the **Pneumovax** today ___Yes ___ No		Hepatitis **B** Vaccine **Series of 3**			
Tetanus/Tdap ___ Never ___ Unknown __ < 10 yrs. __ > 10 yrs.		***Twinrix*** Vaccine **(Hep A&B combo) Series of 3**			
HPV ___Yes ___ No ___Unk ***LIVE VACCINE*		**Tuberculosis/PPD**			
Zoster (shingles) vaccine ___Yes ___ No ___Unk ***LIVE VACCINE*		Previous POSITIVE result ___Yes ___ No			
		Previous NEGATIVE Chest X-RAY ___Yes ___ No			

Name_____
ID# _____
Date of Birth_____/_____/_____

COMMUNITY HEALTH

Have you been **HOSPITALIZED** within the **last year**? ☐ **Yes** ☐ **No**		
When:	**Where:**	**Treated for:**

PAST MEDICAL HISTORY ***(PLEASE CHECK ALL THAT APPLY)***

X	Condition	Year	X	Condition	Year	X	Condition	Year
	AIDS/HIV			Diabetes Type I (Since Birth)			Irritable Bowel Disease	
	ATRIAL FIBRILATION			Diabetes Type II			Liver Disease	
	Arrhythmia (other heart rhythm disorder)			Deep Vein Thrombosis			Lung Disease	
	Anemia			ENT (eye, nose, throat) disorders			MRSA (Where)_____	
	Arthritis			Epilepsy			Myocardial Infarction	
	Asthma			Esophageal Varices			**Low White Blood Cells** requiring hospitalization and/or an Isolation Room	
	Atopic Dermatitis			Gastric Ulcer			Peripheral Vascular Disease	
	Bleeding Disorders			GERD			Prostate	
	Blood Transfusions			Heart Attack			Stroke	
	Breast Cancer			Heart Disease			Thyroid	
	C-Diff			Hepatitis A			Urinary Tract infections (Chronic)	
	Cancer (other): _____ _____			Hepatitis B			Psychiatric/Mental Health diagnosis:_____ _____	
	Cancer (other): _____ _____			Hepatitis C				
	Crohn's			Herpes			OTHER:	
	Congestive **H**eart **F**ailure			Hyperlipidemia (high cholesterol)			OTHER:	
	COPD/Emphysema			Hypertension (high BP)			OTHER:	
	Coronary Artery Disease			Hypotension (low BP)			OTHER:	
	OTHER: ****ABNORMAL PAP SMEAR**			OTHER: **ABNORMAL Breast exam or mamogram**			OTHER:	
	OTHER:			OTHER:			OTHER:	

PAST SURGICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

	Abdominal Aneurism Repair			Coronary Artery Bypass Graft/**CABG**			Joint Replacement_____	
	Adenoids/Tonsilectomy			Gallbladder removed			Prostate Surgery	
	Appendix removed			Heart Surgery			**STENTS** _____	

Name_____
ID# _____
Date of Birth_____/_____/_____

	Breast Cancer Surgery			Hernia Repair			**IMPLANTED PACEMAKER**	
	Carotid Artery surgery			Hysterectomy __Partial__Total			**IMPLANTED DEFIBRILATOR**	
	OTHER:			OTHER:			OTHER:	
	OTHER:			OTHER:			OTHER:	

FAMILY MEDICAL HISTORY

	RELATION	LIVING **Y**=Yes/ **N**=No	AGE	Major Medical Problems and/or Cause of Death
	Father			
	Mother			
	Siblings			

HIV/AIDS HISTORY

	HIV Diagnosis Date	/ /	City and State when 1st Diagnosed:	
	First Service Date AT THIS CLINIC	/ /	Do You CURRENTLY have AIDS?	☐ **YES** ☐ **NO** ☐ **UNKNOWN**
	Prior **AIDS** Diagnosis If yes, date or month/year	/ /	Prior **AIDS** Diagnosis: CITY / STATE:	

MISCELLANEOUS SCREENINGS/LABS

	LAST PAP (WOMEN) ___Positive /____Negative			LAST PSA			LAST ORAL CANCER SCREEN	
	LAST MAMMOGRAM ___Normal /____Abnormal			LAST RECTAL EXAM-**PROSTATE**			LAST BONE DENSITY SCAN	
	# OF PREGNANCIES			LAST COLONOSCOPY			POSITIVE OCCULT BLOOD (STOOL)	
	# OF LIVE BIRTHS			LAST SIGMOIDOSCOPY			OTHER:	
	LAST PAP (ANAL, MALE) ___Positive /____Negative			LAST DENTAL EXAM			OTHER:	
	OTHER:			OTHER:			OTHER:	

	**Currently receiving anti-coagulation (Blood Thinner) therapy other than Aspirin	What medication?	Dose?	Last Pt/INR	Checked how OFTEN?

Name_____
ID# _____
Date of Birth_____/_____/_____

SUBSTANCE USE/ABUSE HISTORY		HOW MUCH/HOW OFTEN	LAST USE	QUIT DATE	REQUEST INFO ON QUITING?
TOBACCO	___Yes ___No				___Yes ___ No
ALCOHOL	___Yes ___No				___Yes ___ No
STREET DRUGS/type	___Yes ___No				___Yes ___ No
PRESCRIPTION NARCOTICS/type	___Yes ___No				___Yes ___ No

Other **MEDICAL** issues not covered in questionnaire which the doctor should know about you.

Printed name **Signature** **Date**

ADDITIONAL MEDICATIONS:

(Continued From Page 1) CURRENT MEDICATIONS Please include **DAILY** Vitamins/herbals and Over the Counter meds at end of list				
Drug Name:	Dose (Mg.;ml.;units)	How often ?	**How long?** MM/Yr Started	**If not from this clinic** the prescribing doctor's name and specialty

Name_____
ID# _____
Date of Birth_____/_____/_____

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statutes, please answer the following questions.

Declaration to Decline Life-Prolonging Procedure (Living Will)

- ☐ I have made such a declaration
- ☐ I have not made such a declaration

Health Care Surrogate

- ☐ I have designated a Health Care Surrogate
- ☐ I have not designated a Health Care Surrogate

Durable Power of Attorney

- ☐ I have appointed a Durable Power of Attorney for Health Care decisions
- ☐ I have not appointed a Durable Power of Attorney for Health Care decisions

Do Not Resuscitate Order (DNR)

- ☐ I have a DNR Order

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT

Name (print) Signature Date

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT, but decline to answer the above questions.

Name (print) Signature Date

PLEASE PROVIDE YOUR HEALTH PROVIDERS WITH COPIES OF ALL YOUR HEALTH RELATED DOCUMENTS.

Name_____

ID# _____

Date of Birth_____/_____/_____

KEEP THIS PAGE FOR YOUR RECORDS. THIS PAGE DOES NOT NEED TO BE RETURNED

The 2017 Florida Statutes

Title XLIV	Chapter 765	View Entire Chapter
CIVIL RIGHTS	HEALTHCARE ADVANCE DIRECTIVES	

765.302 Procedure for making a living will; notice to physician. –

(1) Any competent adult may, at any time, make a living will or written declaration and direct the providing, withholding, or withdrawal of life-prolonging procedures in the event that such person has a terminal condition, has an end-stage condition, or is in a persistent vegetative state. A living will must be signed by the principal in the presence of two subscribing witnesses, one of whom is neither a spouse nor a blood relative of the principal. If the principal is physically unable to sign the living will, one of the witnesses must subscribe the principal's signature in the principal's presence and at the principal's direction.

(2) It is the responsibility of the principal to provide for notification to her or his primary physician that the living will has been made. In the event the principal is physically or mentally incapacitated at the time the principal is admitted to a health care facility, any other person may notify the physician or health care facility of the existence of the living will. A primary physician or health care facility which is so notified shall promptly make the living will or a copy thereof a part of the principal's medical records.

(3) A living will, executed pursuant to this section, establishes a rebuttable presumption of clear and convincing evidence of the principal's wishes.

History.—s. 4, ch. 92-199; s. 1147, ch. 97-102; s. 25, ch. 99-331; s. 14, ch. 2015-153.

NO SHOW POLICY

What is a "No Show"?

Because we reserve a considerable amount of physician and staff time for your healthcare needs, we require **at least 24 hours notice** when rescheduling or cancelling your medical or lab appointment. **Failure to provide at least 24 hours notice to reschedule or cancel your appointment results in a "no show."**

CAN Community Health is a nonprofit organization, committed to spending enough time with our patients to provide excellent, high quality care. Because we pay physicians and other staff to be available for you during your scheduled appointment time, when you don't show up for your appointment, it takes valuable resources away from other patients.

No Show Fees

Failure to provide at least 24 hours advanced notice may result in a no show fee. You will be required to pay any no show fees prior to your next visit, or work out a payment plan with a financial counselor. Our current no show fee will be provided to you during check in at your first visit.

Other No Show Penalties

If you have 2 no shows within a 12 month period, you may be required to schedule during one of our designated no show clinic openings to see one of our doctors. Multiple no shows may result in dismissal from the practice. Please be aware that repeated no shows may also disqualify you from receiving Ryan White services.

Appointment Reminders

Reminders are usually provided as a courtesy in advance of your appointment. We call the phone number you provided, so please let us know immediately if your contact information changes. Also, please consider registering on our confidential patient portal, which allows you to easily update your information and select communication preferences, such as text message or email reminders. Our front desk team is happy to set up the portal for you, or help you if you need a password reset. We appreciate your cooperation, as your advanced notice allows us to help sick patients with urgent needs.

If you need to reschedule or cancel your appointment, please call (844) 922-2777 x11910 as soon as possible to let us know.

I have read and understand this policy. I understand that it is my responsibility to notify the clinic at least 24 hours in advance if I am unable to attend my appointment.

Print Name: _____ Date:_____

Signature: _____

Name_____

ID# _____

Date of Birth_____/_____/_____

Revised 11/30/2017