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

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

Sexual Orientation:

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

Address:

Home Phone:	Would you like more information about our patient portal? ☐ YES ☐ NO
Work Phone:	(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_____/_____/_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

Name: _____

Clinic Location: _____

I have received a copy of the CAN Community Health Privacy Practices

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 i t.***

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 _____/_____/_____

COMMUNITY HEALTH

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_____/_____/_____

COMMUNITY HEALTH

INITIATION OF SERVICES

Client Name: _____

Name of Clinic: _____

Clinic Address: _____

PART I: CONSENT TO ENTERING INTO A CLIENT-PROVIDER RELATIONSHIP I authorize CAN Community Health and their representatives to render routine healthcare. I understand routine healthcare is confidential and voluntary and may involve medical / dental office visits including obtaining medical history and external prescription history, examination, administration of medication, laboratory tests and/or minor procedures. I authorize the use of my photograph, either by upload from government issued ID or on-site photo, to be used as visual recognition for healthcare visits and safety precautions. 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 healthcare 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 healthcare 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

Name_____
ID# _____
Date of Birth_____/_____/_____

Revised 5/3/2019

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

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

REQUEST RECORDS FROM:

Person/Facility: _____ Phone #: _____

Address: _____ Fax #: _____

SEND RECORDS TO:

Person/Facility: _____ Phone #: _____

Address: _____ Fax #: _____

Other method of communication:

I SPECIFICALLY AUTHORIZE RELEASE OF INFORMATION RELATING 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 have 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 Date

Name_____
ID# _____
Date of Birth_____/_____/_____

CONSENT FOR EMAIL/TEXT COMMUNICATION

Unencrypted email 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 email 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 email or text messages from your computer, phone or another mobile device.

By signing below, you may consent to receive email and/or text messages from us regarding your treatment. Email 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 email or text to you will verify the email address or mobile phone number you provided.

Please initial next to your choice regarding email or text communication:

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

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

Email address: _____

Mobile phone number: (_____) _____

Mobile phone provider: _____

_____I do not consent to receiving any information via email or text message.

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

If I send an email 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 5/3/2019

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): _____

_____

_____

Name_____
ID# _____
Date of Birth_____/_____/_____

COMMUNITY HEALTH

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)

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.**

Name_____
ID# _____
Date of Birth_____/_____/_____

Revised 5/3/19

_____

COMMUNITY HEALTH

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.		***Tw inrix*** 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			

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

Name_____
ID# _____
Date of Birth_____/_____/_____

COMMUNITY HEALTH

PAST MEDICAL HISTORY *(P LEASE CHECK ALL THAT A PPLY)*

Condition	*X*	*Year*	*Condition*	*X*	*Year*	*Condition*	*X*	*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 mammogram**			OTHER:		
OTHER:			OTHER:			OTHER:		

Name_____
ID# _____
Date of Birth_____/_____/_____

Revised 5/3/2019

COMMUNITY HEALTH

PAST SURGICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

Condition	X	Year	Condition	X	Year	Condition	X	Year
Abdominal Aneurism Repair			Coronary Artery Bypass Graft/**CABG**			Joint Replacement_____		
Adenoids/Tonsillectomy			Gallbladder removed			Prostate Surgery		
Appendix removed			Heart Surgery			**STENTS** _____		
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 Yes/ **N**=No	AGE	**Major Medical Problems and/or Cause of Death**
Father			
Mother			
Siblings			

Name_____
ID# _____
Date of Birth_____/_____/_____

COMMUNITY HEALTH

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?

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

Name_____
ID# _____
Date of Birth_____/_____/_____

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

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

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

Name_____
ID# _____
Date of Birth_____/_____/_____

PATIENT SELF-DETERMINATION ACT QUESTIONNAIRE

To comply with the Omnibus Budget Reconciliation Act of 1990, Chapter 745, Florida Statutes, and South Carolina Code of Law 44 (please welcome packet for more information), 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_____/_____/_____

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 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 not-for-profit 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 will 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.

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 (941) 366-0134 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 5/3/2019

COMMUNITY HEALTH

PATIENT PORTAL

Our patient portal allows you confidential, 24-hour access to your medical records. It also enables patients to communicate with our practice in a convenient, safe and secure way.

Benefits of using the portal:

- Send Refill Requests
- Keep track of personal medical information
- Send messages to nursing
- Update personal information
- Receive health maintenance reminders
- Receive patient education
- See your upcoming appointments
- See your lab results

Easy sign-up!

Name: _____

Date of Birth: _____

Email Address: _____

PLEASE DO NOT USE THE PORTAL FOR URGENT NEEDS

Name_____
ID# _____
Date of Birth_____/_____/_____

Revised 5/3/2019