PATIENT REGISTRATION FORM

Today's Date: _____ Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Sex at Birth: ☐Male ☐Female Social Security: _____

Preferred Name: _____ Preferred Pronouns: _____

Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

How Did You Hear About Us?: _____

Sexual Orientation:
☐Lesbian, Gay, or Homosexual
☐Straight or Heterosexual
☐Bisexual
☐Prefer Not to Disclose
☐Sexual Orientation Identity: _____

Gender Identity:
☐Male
☐Female
☐Non-Binary
☐Androgynous
☐Female-to-Male (FTM) / Transgender Man / Trans Man
☐Male-to-Female (MTF) / Transgender Female / Trans Woman
☐Gender queer, neither exclusively male nor female
☐Prefer not to Disclose
☐Gender Identity: _____

Marital Status: ☐Married ☐Divorced ☐Partner ☐Single ☐Widowed ☐Legally Separated

Preferred Language (Idiomia preferida): _____ Would you like a Translator? (Gustaria interprete): _____

Race: ☐Asian ☐Black or African American ☐Haitian ☐Pacific Islander ☐White ☐Other Race: _____

Ethnicity: ☐Cuban ☐Hispanic or Latino ☐Latin American ☐Mexican ☐Not Hispanic or Latino ☐Puerto Rican
☐Prefer not to Disclose ☐Other Ethnicity: _____

Insurance Information

Do you have health insurance? ☐Yes ☐No

If Yes, *please bring your insurance card(s) to your first appointment.*

Insurance: _____ 2nd Insurance: _____

Member ID: _____ 2nd Member ID: _____

If No, there may be options available – please speak to office staff to explore available options.

Primary Care Doctor Name: _____ Primary Care Phone: _____

Emergency Contact Information

Name of local friend or relative: _____

Relationship to patient: _____ **Cell phone**: _____ **Home phone**: _____

Name of local friend or relative: _____

Relationship to patient: _____ Cell phone: _____ Home phone: _____

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

Patient/Guardian Signature: _____ **Date:** _____

This Section is for Office Use ONLY

Patient Name: _____

Pt DOB: _____

Pt ID#: _____

Last Revised 01/13/2021

INITIATION OF SERVICES

Part I: CLIENT-PROVIDER RELATIONSHIP CONSENT

Client Name: _____

Name of Agency: _____

Agency Address: _____

I consent to entering a client-provider relationship. I authorize CAN Community Health, Inc. and their representatives to render routine healthcare. I understand routine healthcare 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 operation 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. Substance Use Disorder medical information will not be disclosed without additional authorization in accordance with 42 CFR part 2.

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 | Relationship to Client | Date of Birth

_____

Client/Representative Printed Name

_____ _____

Witness | Date

Part VI: WITHDRAWAL OF CONSENT

I, _____ withdraw this consent, effective _____

Client/Representative Signature | Date

_____ _____

Witness | Date

This Section is for Office Use ONLY

Patient Name: _____

Pt DOB: _____

Pt ID#: _____

Last Revised 01/13/2021

PATIENT CONSENTS AND ACKNOWLEDGEMENTS

1. Notice of Privacy Practices

Initials: _____

I acknowledge that I have received the practice's Notice of Privacy which describes the ways in which the practice may use and disclose my healthcare information for its treatment and payment/healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Compliance Officer if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy. These documents are posted in the lobby. I acknowledge that I have received a copy of each.

(This section is for CAN office staff usage only): Good Faith Effort

The following good faith efforts were made to obtain the individual's or representative's signature on (date):_____

☐Face to Presentation ☐Telephone Contact ☐Mailing ☐Email ☐Other: _____

Staff Signature: _____

2. Patient Portal

Initials: _____

Our patient portal allows you confidential, 24-hour access to your medical records and allows patients to communicate with our practice in a convenient, safe and secure way. After signing up, you will have the ability to submit refill requests, send messages to the nursing department, update personal information as needed, and review upcoming appointments. Provide an email and get signed up today! **CAN Community Health, Inc. (CAN)** offers a secure and easy online payment option for the portion of services that your insurance does not cover. Payment can be made online in your patient portal. Your credit card information will not be saved by CAN.

3. Telehealth

Initials: _____

I understand that it may be necessary to schedule visits with a CAN Community Health, Inc. provider on a telehealth platform. For a telehealth appointment I will ensure I have a secure, private location with reliable internet access and plan to arrive 15 minutes prior to my appointment time to login work though any technical issues that I may have. I will be responsible for any co-pays. I understand that my provider is licensed in the state I am registered to receive services and the laws of the state in which I am located will apply to my receipt of telehealth services.

- Potential benefits of telehealth (which are not guaranteed or assured) include: (i) access to medical care if I am unable to travel to my CAN provider's office; (ii) more efficient medical evaluation and management; and (iii) during the COVID-19 pandemic, reduced exposure to patients, medical staff and other individuals at a physical location.
- Potential risks of telehealth include: (i) limited or no availability of diagnostic laboratory, x-ray, EKG, and other testing, and some prescriptions, to assist my medical provider in diagnosis and treatment; (ii) my provider's inability to conduct a hands-on physical examination of me and my condition; and (iii) delays in evaluation and treatment due to technical difficulties or interruptions, distortion of diagnostic images or specimens resulting from electronic transmission issues, unauthorized access to my information, or loss of information due to technical failures. I will not hold CAN responsible for lost information due to technological failures.

4. No Show Policy

Initials: _____

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 advance notice may result in a $35 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 if charged a no-show fee.
- If you have two 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.
- Reminders are provided via the phone number you provided as courtesy ahead of your scheduled appointment date. Let us know immediately if you contact information changes. Please consider signing up for our confidential patient portal (see number 2), which allows you to easily update your information.
- If you need to reschedule or cancel your appointment, please call (844) 922-2777 and dial prompt 3 for scheduling.

This Section is for Office Use ONLY

Patient Name:_____

Pt DOB: _____

Pt ID#:_____

COMMUNITY HEALTH

5. Consent for Use and Disclosure of Protected Health Information (PHI) **Initials:**_____

- May we call your job and leave a message? ☐Yes ☐No
  If yes, at that phone number?_____
- May we call your home and leave a message? ☐Yes ☐No
  If yes, at what phone number?_____
- May we leave a message concerning medical information on your cell phone? ☐Yes ☐No
  If yes, at what phone number?_____

6. Consent to Email or Text Message for Appointment Reminders and Other Healthcare Communications **Initials:** _____

- **Part 1: Consent to Email/Text**

Patients in our practice may be contacted via email and/or text messaging for appointment reminders and general health information. If at any time I, the patient, provide an email or mobile number at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or mobile number from the practice. I consent to and accept the risk in receiving appointment/information via email or text message.

Emails and text messages will be part of your medical record -we will use the minimum amount of information necessary in any communication. Please check off the appropriate boxes and complete as needed.

☐ **I consent** to receive **TEXT** messages for appointment reminders, feedback, and general health reminders/information at this mobile number: _____

☐ **I consent** to receive **EMAIL** messages for appointments reminders, feedback, and general health reminders/information at this email: _____

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

- **Part 2: Revocation If You Do Not Want to Receive Email/Text**

☐ **I do NOT** consent and hereby revoke my request to receive **EMAIL** messages for appointment reminders, feedback, and general health reminders/information

☐ **I do NOT** consent and hereby revoke my request to receive **TEXT** messages for appointment reminders, feedback, and general health reminders/information

_____ _____

Patient or Parent/Guardian Signature Date

_____ _____

Patient or Parent/Guardian Signature **Date**

This Section is for Office Use ONLY

Patient Name:_____

Pt DOB: _____

Pt ID#:_____

Last Revised 01/13/2021

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

Patient Name: _____ DOB: _____

INFORMATION MAY BE DISCLOSED/RELEASED BY:

Person/Facility: _____ Phone #: _____

Address: _____ Fax #: _____

INFORMATION MAY BE DISCLOSED/RELEASED TO:

Person/Facility: _____ Phone # _____

Address: _____ Fax #: _____

Other method of communication: _____

INITIAL – I SPECIFICALLY AUTHORIZE RELEASE OF INFORMATION RELATING TO: Date Range: _____

____ General Medical Records ____ History & Physicals ____ Progress Notes ____ Family Planning

____ Mental Health (excluding psychotherapy notes) ____ Substance Use Disorders ____Sexually Transmitted Diseases

____ Psychotherapy Notes: If selected, no other item on this form 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): _____

____ HIV/AIDS related information and treatment ____ ***HIV/AIDS related information may be sent via fax***

____ Other: _____

____ All of my health information that the providers have in their possession, including information relating to any medical history, mental health (excluding psychotherapy), or physical condition and any treatment received by me

PURPOSE OF DISCLOSURE: ☐ Continuity of Care ☐ Personal Use ☐ Other (specify): _____

EXPIRATION DATE: This authorization will expire (insert date or event)_____. I understand that I fail to specify an 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. Any information covered under 42 CFR part 2 will not be redisclosed. You understand that completing this authorization form is voluntary and that treatment will not be denied if you refuse to sign this form. You may request a list of protected health care information disclosures made on your behalf.

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

NJ - If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New Jersey Civil Rights Commission at (973) 648-2700

_____ _____

Client/Representative Signature Date

_____ _____

Printed Name Relationship to Client

_____ _____

Witness (Optional) Date

This Section is for Office Use ONLY

Patient Name:_____

Pt DOB: _____

Pt ID#:_____

Last Revised 01/13/2021

PATIENT SELF-DETERMINATION ACT QUESTIONNAIRE

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 do not 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

This Section is for Office Use ONLY

Patient Name:_____

Pt DOB: _____

Pt ID#:_____

Last Revised 01/13/2021

GRIEVANCE PROCEDURE

All persons, regardless or race, ethnic origin, economic status, sexual orientation or religious affiliation, will have access to services at CAN Community Health, Inc.. CAN agrees to comply with the provisions or Title VI or the Civil Rights Act. It is CAN's policy that all complaints are resolved in a multi-layered manner, beginning at the lower level. Every effort will be made to resolve VERBAL complaints or appeals as soon as possible. **All grievances will remain confidential** and there shall be no reprisal towards the clients when grievances are made.

1. All complaints, verbal or written, should be directed to the clinic Practice Administrator who will work closely with the employee delivering the complaint to provide appropriate direction and supervision. The Practice Administrator will observe the employee's performance, then discuss his/her/their findings with the client. All complaints, verbal or written, shall be acknowledged within 2 business days.
2. The Practice Administrator will notify the Sr. Director of Clinical Operations.
3. Discussion of the problem between the client and Practice Administrator shall occur and a resolution presented within 10 business days.
4. If the client is unsatisfied with the results of the discussion or meeting, the client may request a hearing with the Director of Clinical Operations.
5. Any client or potential client who has a grievance may file a WRITTEN complaint to the Director of Clinical Operations addressed to the CAN Community Health, Inc. headquarters location:

   CAN Community Health, Inc.
   Attn: Sr. Director of Clinical Operations
   4440 Fruitville Rd.
   Sarasota, FL 34232

6. Discussion of the problem between the client and the administrator of his/her/their designee shall occur within 30 days of the original written report.
   a. Clients may further appeal pursuant to respective state statutes
   b. Grievances regarding Ryan White funded services may also be registered in the client's county of residence, local social services, and/or local county health department of those funds.

Client Signature _____ Client Printed Name _____ Date _____

This Section is for Office Use ONLY

Patient Name:_____

Pt DOB: _____

Pt ID#:_____

Last Revised 01/13/2021