Crestview Health/Dental Center | New Patient Registration

Patient's SSN

Patient Name (First) (Middle) (Last) Birth Date

Gender ☐ Female ☐ Female-to-Male/Trans Man ☐ Male ☐ Male to Female/TransWoman

☐ GenderQueer, Neither Exclusively Male Nor Female ☐ Refuse to Report ☐ Other- Specify:

Street Address County

City State Zip

Mailing Address

City State Zip

Home Phone ( ) Work Phone ( )

Cell Phone ( ) Email Address

Patient's Relationship to Insured?

☐ Self ☐ Child ☐ Spouse ☐ Guardian ☐ Other: Specify

Please present your insurance card to the front desk receptionist when returning this form

Name of Guarantor or Responsible Party

Street Address

Mailing Address

City State Zip

Birth Date Guarantor's SSN

Gender ☐ Female ☐ Male Guarantor's Employer

Home Phone ( ) Work Phone ( ) Cell Phone: ( )

Insurance Coverage (If same as above, write "SAME")

Name of Guarantor or Person paying for visit

Street Address Insurance Co. Name

Mailing Address Policy # and Group Name

City State Zip

Birth Date Guarantor's SSN

Gender ☐ Female ☐ Male Guarantor's Employer

Home Phone ( ) Work Phone ( ) Cell Phone ( )

Additional Patient Information

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

☐ Life Partner ☐ Legally Separated ☐ Separated ☐ Unknown

Patient's Employment Status ☐ Full time ☐ Part time ☐ Student

☐ Disabled ☐ Retired ☐ Unemployed

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Spouse's Employment Status ☐ Full time ☐ Part time ☐ Student ☐ Disabled ☐ Retired ☐ Unemployed

Name of Participating Pharmacy offering 340B Discounted Prescriptions: Prescription Shoppe

Do you prefer another Pharmacy? If so, Which?

Language Best Served ☐ English ☐ Spanish ☐ Sign Language ☐ Other: Specify:

Interpreter Service Needed ☐ Yes ☐ No **Homeless** ☐ Yes ☐ No

Over the last 2 years have you OR the person you depend upon: (If applicable, Check all that apply)

☐ Been hired to do farm work or pick fruit? ☐ Done farm work on an annual or seasonal basis?

☐ Earned most of your income by doing farm work? ☐ Spent at least 1 night away from home doing farm work?

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Unreported

Ethnicity ☐ Hispanic/Latino ☐ Another Hispanic, Latino or Spanish Origin ☐ Cuban ☐ Mexican, Mexican American, Chicano ☐ Puerto Rican ☐ Not Hispanic/Latino ☐ Unreported

Patient's Driver's License # **Veteran?** ☐ Yes ☐ No

How did you hear about us? ☐ Community Event ☐ Drive By ☐ Family ☐ Health Fair ☐ Post card ☐ Hospital ☐ Internet ☐ Employer ☐ Newspaper ☐ Health Dept ☐ Phone Book ☐ Confinement Center ☐ Doctor's Office ☐ Insur/Social Services ☐ Other: Specify

Emergency Contact Information

Name _____ Relationship _____

Does Patient live with Emergency Contact? ☐ Yes ☐ No

Home Phone ( ) _____ Work Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Consent and Financial Responsibility Agreement

I/We hereby grant Crestview Health Center permission to treat myself and/or my child/ward for any illness or injury that I/we may encounter. I/We hereby authorize Crestview Health Center to furnish all information regarding my medical history, diagnosis and treatment of myself or my child (if applicable) to an insurance company regarding my claims for benefits. If however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, I/We agree to be responsible for the fee and cost involved in the treatment of the above named patient. I/We authorize payment of medical benefits to Crestview Health Center and agree that should I receive any payments directly from any insurance companies for services billed on my behalf by the center, that I will turn those payments over to the Crestview Health Center immediately. I further understand that should my account have to be referred to a collection agency that I am responsible for all fees and costs incurred therein. I/We hereby authorize Crestview Health Center to act on my behalf in accessing my medical records when and if needed.

Patient's Lifetime Signature or parent/legal guardian _____ Patient's Name (print) & Date _____

Consent to the Use and Disclosure of Individually Identifiable Health Information for Treatment, Payment, and/or Health Care Operations

I, _____, understand that as a part of my health care, North Florida Medical Centers, Inc. (NFMC) receives, originates, maintains, discloses, and uses individually identifiable health information, including, but not limited to, health records and other health information describing my health history, symptoms, examination and test results, diagnoses, treatment, treatment plans, and billing and health insurance information. I understand that NFMC and its physicians, other health care professionals, and staff may use this information to perform the following tasks:

- Diagnose my medical/psychiatric/psychological condition.
- Plan my care and treatment.
- Communicate with other health professionals concerning my care.
- Document services for payment/reimbursement.
- Conduct routine health care operations, such as quality assurance and peer review.
- For research and similar purposes designed to improve the quality and to reduce the cost of health care.

I have been provided a ***Notice of Information Practices*** that fully explains the uses and disclosures that NFMC will make with respect to my individually identifiable health information. I understand that I have the right to review the *Notice* before signing this consent. NFMC has afforded me sufficient time to review this *Notice* and has answered any questions that I have to my satisfaction. I also understand that NFMC cannot use or disclose my individually identifiable health information other than as specified on the *Notice*. I also understand, however, that NFMC reserves the right to change its notice and the practices detailed therein prospectively (for uses and disclosures occurring after the revision) if it posts a copy of the revised notice in a prominent space in the medical center(s).

I understand that I do not have to consent to the use or disclosure of my individually identifiable health information for treatment, payment, and health care operations, but that if I do not consent, NFMC may refuse to provide me health care services unless applicable state or federal law requires NFMC to provide such services.

I understand that I have the right to request restrictions on the use or disclosure of my individually identifiable health information to carry out treatment, payment, or health care operations. I further understand that NFMC is not required to agree to the requested restriction but that, if it does agree, it must honor the restriction unless I request that it stop doing so or NFMC notifies me that it is no longer going to honor the request.

I understand that I have the right to request restriction as to the method of communications to me. I understand that I may revoke this consent in writing but that the revocation will not be effective to the extent that NFMC has already taken action in reliance on my earlier effective consent.

I request the following restrictions on the use or disclosure of my individually identifiable health information: _____

_____

I object to uses and disclosures as follows: _____

_____

_____

Signature of Patient or Legal Representative _____ Signature of Witness _____

Date _____ _____

For Office Use Only: _____

_____

_____

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from the North Florida Medical Centers, Inc. A summary of your rights and responsibilities follows:

NORTH FLORIDA MEDICAL CENTERS, Inc.

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

MISSION: To provide quality health care to all people in a cost-effective and caring manner.

AS A PATIENT, YOU HAVE THE RIGHT TO:

1. Be treated with courtesy and respect, with appreciation of your individual dignity, and with protection of your need for privacy.
2. Prompt and reasonable response to questions and requests.
3. Know who is providing medical services and who is responsible for your care.
4. Know what patient support services are available, including whether an interpreter is available if you do not speak English.
5. Know what rules and regulations apply to your conduct.
6. Be given, by the health care provider, information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
7. Refuse any treatment, except as otherwise provided by law.
8. To be given, upon request, full information and necessary counseling on the availability of known financial resources for your care.
9. (If you are a patient eligible for Medicare), to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
10. To receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
11. Receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
12. Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
13. Treatment for any emergency medical condition that should deteriorate from failure to provide treatment.
14. Know if medical treatment is for purposes of experimental research and to give your consent or refusal to participate in such experimental research.
15. Express grievances regarding any violation of your rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility that served you and to the appropriate state licensing agency.

AS A PATIENT, YOU HAVE THE RESPONSIBILITY TO:

1. Provide to the health care provider, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to your health.
2. Reporting unexpected changes in your condition to the health care provider.
3. Reporting to the health care provider whether you comprehend a contemplated course of action and what is expected of you.
4. Following the treatment plan recommended by the health care provider.
5. Keeping appointments and, when you are unable to do so for any reason, notifying the health care provider or health care facility.
6. Be responsible for your actions if you refuse treatment or do not follow the health care provider's instructions.
7. Assuring that the financial obligations of your health care are fulfilled as promptly as possible.
8. Following health care facility rules and regulations affecting patient care and conduct.

RECEIPT OF PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

I, _____(Print name) have received a copy of the Patient Bill of Rights and Responsibilities and have read them or had them read to me.

_____

Signature of Patient Date

_____

Signature of staff member Date

Crestview Dental Center

Insurance Coverage Waiver

Pt Name: **Birthdate:** **Pt#:**

I understand that my eligibility for coverage of today's services cannot be confirmed at this time.

I wish to receive medical/dental services from Crestview Dental Center

If it is determined that I am not eligible for coverage of all services received today, I understand that I will be responsible for payment of non-covered services provided.

I acknowledge I have been advised of my responsibility of non-covered services BEFORE being seen by the clinical provider.

Patient or Guarantor Signature Date:

North Florida Medical Centers, Inc.

*Corporate Office: 2804 Remington Green Circle * Tallahassee, FL 32308 * Phone: (850) 385-4494 * Fax (850) 298-6051*

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North Florida Medical Centers, Inc.

Crestview Health Center
800 Hospital Dr.
Crestview, FL 32539
850-682-1164

Patient date of birth:

To whom it may concern:

"No-Show" Policy

A missed appointment ("No-Show"), without a call to reschedule, prevents Crestview Health Center from being able to provide care for other patients.

If you have a scheduled appointment and will not be able to make it, we ask that you please give us a call to reschedule so that we can offer every patient the opportunity to schedule an appointment.

Also, please be aware that if you are more than 15 minutes late to your scheduled appointment, you may be asked to reschedule or will be worked into our schedule if possible.

Patients that have missed three (3) or more appointments as a "No-Show" will no longer be able to schedule appointments in advance. In this case, patients will need to arrive at 8:00am the day they wish to be seen and be worked into our schedule for the morning.

Thank you in advance for helping us increase access to health care for our community.

Your Crestview Health Center Team

Need patient's signature or guarantor in Box