North Florida Medical

New Patient Registration Form

Todays' Date: _____

Health Center Location: _____

Patient Last Name: _____First Name: _____ Middle Initial: _____

Previous Name *(if applicable)*: _____

Address:_____City:_____Zip:_____State:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Date of Birth: _____ Social Security: _____

Sex: __ Male __ Female __Unknown **S.O. /G.I Birth Sex**: __ Male __ Female __Unknown

Sexual Orientation

□ Lesbian, gay, or Homosexual
□ Straight or Heterosexual
□ Bisexual
□ Do not know
□ Choose not to disclose
□ Something else (please describe):
_____

Gender Identity

□ Male □ Female
□ Female to Male/Transgender Man
□ Male to Female/Transgender Woman
□ Genderqueer, not Male nor Female
□ Choose not the disclose
□ Transgender
Additional gender (please describe):
_____

Responsible Party		
Name:	Date of Birth:	
Address:	Relation:	Phone:

Emergency Contact: _____ Phone Number: _____
Relation: _____ Address: _____

Marital Status:

__Divorced __Married __Partner __Single __Unknown __Widowed __ Separated

Primary Language:_____**Translator required**: ____ Yes____ No

Race

□ American Indian or Alaska Native
□ Asian
□ Native Hawaiian or other Pacific Islander
□ Black or African American
□ White
□ Other Pacific Islander
□ Other Race □ Declined to Specify

Ethnicity

□ Hispanic or Latino
□ Not Hispanic or Latino
□ Declined to Specify

Patient Name: _____

Release of Information: (HIPAA)___Yes___No **Rx History Consent:**___Yes___No

Advanced Directive:___N/A (Not applicable)___Yes__ No

Employment: __ Full-time __ Part-time __Not Employed __ Self-employed __Retired
__ Military active duty __ Unknown

Student Status: __ Full-time __ Not a Student __ Part-time

Primary Insurance
Name:
Insured Name:
Policy Number:
Relation to Insured:

Secondary Insurance
Name:
Insured Name:
Policy Number:
Relation to Insured:

Patient's Alternate Name, if applicable (Last, First, MI): _____
Insured's Alternate Name, if applicable (Last, First, MI): _____

Pharmacy #1
Name:
Address:
Primary: Yes or No (circle)

Pharmacy #2
Name:
Address:
Primary: Yes or No (circle)

Additional Information *(If different from mailing address)*

Address:_____City:_____ State:_____Zip:_____

Employer Name:_____Address:_____

How did you hear about us?

__ Billboard __ Community event __ Confinement facility __Doctors office __Drive by

__ Employer __Family __ Friend __ Health Dept. __ Health Fair __ Hospital

__ Insurance/Soc. Serv. __ Internet __ Newspaper __ Nursing Home __ Outreach

__ Phonebook __ Postcard __ Realty Company __ School__ Other (please specify): _____

Veteran:__Yes___No **Seasonal Farm work**:_Yes___No **Migrant farm work**:_Yes___No

Patient Name: _____

Homeless: __ Yes __ No

If Yes, Homeless Status: __ Unknown __Street __ Doubling Up __ Transitional Housing

__ Homeless Shelter __ Other

Public Housing: __ Yes __No

Limited English in speaking, writing, or understanding___Yes___No

Additional Contacts

Name:_____Relation:_____Phone:_____

Name:_____Relation:_____Phone: _____

Consent and Financial Responsibility Agreement

I/We hereby grant North Florida Medical Center's Inc. (NFMC) permission to treat myself and/or my child/ward for any illness or injury that I/we may encounter. I/We hereby authorize NFMC 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 NFMC 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 NFMC 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 NFMC to act on my behalf in accessing my medical records when and if needed.

_____ _____

Patient's or Parent/Legal Guardian Lifetime Signature **Patient's Name (Print) and Date**

Rev. 03/18, 04/21, 6/21

North Florida Medical Centers, Inc.

Patient Medical, Family, and Social History Patients 65 years and up

Today's Date: _____ Name: _____ Date of Birth: _____

Current Medications: List all medications that you currently use (prescriptions, over the counter medications, and vitamins)

Medications used regularly	What dose or strength?	How do you use it? (How much or how many tablets? How many times per day?

Drug Allergies: _____

Food/Environmental Allergies: _____

Past Medical History

Which medical conditions do you have or have you had in the past? (Check all that apply)

EYE & EAR PROBLEMS	HEART/VASCULAR PROBLEMS	LUNG PROBLEMS
☐ Cataracts	☐ High blood pressure	☐ Asthma
☐ Glaucoma	☐ Irregular heartbeat (arrhythmias)	☐ Bronchitis
☐ Macular degeneration	☐ Heart failure	☐ Emphysema
☐ Hearing loss/Hearing Aid	☐ Heart attack Year:_____	☐ Sleep apnea
	☐ Hyperlipidemia	
☐ Other, specify	☐ Drop in Blood Pressure	☐ Other, specify
	☐ Other, specify	_____

BONE/JOINT PROBLEMS	GLAND PROBLEMS	KIDNEY & URINARY TRACT PROBLEMS
☐ Arthritis	☐ Diabetes	☐ Kidney disease
☐ Osteoporosis	☐ Overactive thyroid - high	☐ Prostate disease
☐ Fracture of hip, wrist, or spine (circle)	☐ Overactive thyroid - low	☐ Bladder/Kidney infections
☐ Gout	☐ Other, specify	☐ Urinary incontinence
☐ Other, specify		☐ Other, specify

GASTROINTESTINAL PROBLEMS	NERVOUS SYSTEM PROBLEMS	OTHER HEALTH PROBLEMS (circle all that apply)
☐ Ulcers	☐ Stroke	☐ Allergies, specify:
☐ Reflux/hiatal hernia	☐ Dementia or Alzheimer's disease	_____
☐ Diverticulosis	☐ Parkinson's disease	☐ Anemia
☐ Liver Disease/cirrhosis	☐ Epilepsy or seizures	☐ Hernia
☐ Hepatitis	☐ Tremor	☐ Thrombosis (blood clots)
☐ Polyps	☐ Neuropathy	☐ Depression
☐ Gallbladder disease	☐ Other, specify	☐ Sexual Dysfunction
☐ Irritable Bowel		☐ Cancer, specify:
☐ Other, specify		☐ Other, specify:
		_____

Surgeries – Inpatient and Outpatient

Date	Surgery

Other Hospitalizations

Date	Reason for Hospitalization

FAMILY HISTORY *Please check (√) all that apply*
Status: A=Alive, D=Deceased, U=Unknown

Relatives - Family Members	Status	Birth Year	Age (Years)	Diabetes	Hyper tension	Heart Disease	Mental Illness	Cancer	Other
Daughter(s)									
Father									
Friend(s)									
Son(s)									
Spouse									
Mother									
Paternal Grandfather									
Paternal Grandmother									
Maternal Grandfather									
Maternal Grandmother									
Paternal Uncle									
Paternal Aunt									
Maternal Uncle									
Maternal Aunt									
Siblings									
Children									

Number of Siblings = Brothers ___ Sisters ___ Healthy Notes: _____

Number of Children = Sons ___ Daughters ___ Healthy Notes: _____

SOCIAL HISTORY (Comprehensive Health Assessment)

Family characteristics: # of Adults in the household ____ # of Children in the household_____

Communication needs:

Hearing □ Yes □ No
Vision □ Yes □ No
Cognition (Understanding) □ Yes □ No

Social Life: Do you consider yourself a social person? __Yes __ No

Advanced Care Planning: __Yes __ No __ Declined __ Refused __ NA

Social Determination of Health: Are you exposed to crime in your neighborhood? __Yes __ No

Geriatric Social History

With whom do you live? (Check one)
□ Alone
□ Spouse or Partner
□ Child or Family Member
□ Friend
□ Other, specify

Which of the following best describes your residence? (check one)
□ Single family home
□ Condo or apartment
□ Live with other in their house, condo or apartment
□ Other, specify
Are there stairs in your home? Yes No

Are you currently
(Check one)

□ Married
□ Divorced
□ Separated
□ Widowed
□ Single (never married)
□ Living with significant other
□ Other, specify:

How many children do you have? _____

Are you in regular contact with your children?

□ Yes □ No

Are you in regular contact with your relatives?

□ Yes No

How much school did you complete?
(check one)

□ Less than 6th grade
□ Less than high school
□ High school graduate
□ Some college
□ College - undergraduate
□ College - graduate or doctorate

What was your principle occupation?

_____

Are you currently…(check one)

□ Retired, not working
□ Working Part-time
□ Working Full-time
□ Unemployed (but not retired)

Occupational exposure:

__ None __ Toxic chemicals __Noise __Infectious agents __ Repetitive physical stress

Assistance at Home

Do you employ someone to provide care or help in your home? __ Yes __ No

If yes, how many hours a day and how many days a week is the person available for you? ___ hours/day ____ days/week

Is this time sufficient to meet your needs? __ Yes __ No

Do you get help from family member or friend in your home? __ Yes __ No

If yes, how many hours a day and how many days a week is the person available for you? ___ hours/day ____ days/week

Is this time sufficient to meet your needs? __ Yes __ No

Who would you call if you were sick or needed help? _____

Do you provide care for a family member? __ Yes __ No

FICA Spiritual History

Do you have spiritual beliefs that help you cope with stress/difficult times? __Yes __ No

If No, what gives your life meaning? _____

Have your beliefs influenced how you take care of yourself? __Yes __ No

Are you a part of a spiritual or religious community? __Yes __No

If yes, is this of support to you, and how? _____

How would you like me to address these issues in your health care?

_____

Daily Functioning

Do you require help with the following? If yes, who helps you?

TASK	NEED HELP	WHO HELPS YOU? (name and relationship)
Feeding yourself	☐ Yes ☐ No	
Getting from bed or chair	☐ Yes ☐ No	
Getting to the toilet	☐ Yes ☐ No	
Getting dressed	☐ Yes ☐ No	
Bathing	☐ Yes ☐ No	
Walking safely	☐ Yes ☐ No	
Using the telephone	☐ Yes ☐ No	
Taking medications	☐ Yes ☐ No	
Preparing meals	☐ Yes ☐ No	
Managing money/financial affairs	☐ Yes ☐ No	
Doing laundry	☐ Yes ☐ No	
Doing house work	☐ Yes ☐ No	
Shopping for groceries	☐ Yes ☐ No	
Driving	☐ Yes ☐ No	
Doing "handyman" work	☐ Yes ☐ No	
Climbing Stairs	☐ Yes ☐ No	
Getting places beyond walking distance	☐ Yes ☐ No	

Additional Family History

Have any of your family had any of the following conditions?							
	Father	**Mother**	**Brother /Sister** (indicate which)	**Brother /Sister** (indicate which)	**Brother /Sister** (indicate which)	**Brother /Sister** (indicate which)	**Brother /Sister** (indicate which)
Dementia or Alzheimer's							
Cancer, Specify							
Heart disease or stroke							
Diabetes							
Depression							

Falls and Mobility

Do you use a walking or mobility aid? __ Yes __ No

Are you afraid of walking? __ Yes __ No

Have you had a fall in the last year? __Yes __ No

Prior fall? (Date) _____

Did the prior fall require doctor or other medical treatment? __Yes __ No

Driving

If you do not drive, how do you get around?
□ Family or Friends
□ Cab
□ Dial a Ride
□ Public bus
□ Other

Do your friends or family have concerns about you driving?
□ Yes □ No

In the past year, have you had any of the following? (select all that apply)

□ Accidents or crashes

□ Tickets

□ Near misses

Have you ever got lost driving? □Yes □ No

Do you always wear your seatbelt when you drive or ride in a car? __ □ Yes __ □ No

Health Maintenance

Do you currently participate in any regular fitness activity? __ Yes __ No

How many minutes do you exercise each week? _____

Recent Hospitalization

Most recent Hospital/ER visit date? _____ Follow-up date? _____

Discharged from **Hospital/ER**? __ Yes __ No

Tobacco Use

__ Smoker __ Former smoker __ Nonsmoker

How many/how often? _____

Do you ___Chews tobacco __Pipe smoker __Snuff user

Are you another tobacco user: __ Yes __ No If yes, what kind? _____

Sexual History

Had sex in the past 12 months (vaginal, oral, or anal)? __ Yes __No

__With Men only __With Women only __Both Men and Women

Do you use protection? __Yes __No

If yes, how often? __ All of the time __Most of the time __ Half the time __Some of the time

Prevention strategies to discuss __Abstinence __ Condoms __ Other

Have you had any sexually transmitted disease (STD)? __ Yes __ No

If yes, which one(s) __Chlamydia __Gonorrhea __Syphilis __ Herpes __Other

Are you having any sexual problems? __ Yes __ No

How many sexual partners have you had? _____ Sexual Abuse __ Yes __No

Drugs and Alcohol

Have you used drugs other than those for medical reasons in the past 12 months? __ Yes __ No

If "Yes", which drug(s) _____

Alcohol		
Did you have a drink containing alcohol in the past year? □Yes □ No If "Yes" how often? □ Never □ Monthly or less □ 2-4 times per month □ 2-3 times per week □ 4 or more a week	If "Yes", How many drinks did you have on a typical day when you were drinking in the past year? □ 1 or 2 drinks □ 3 or 4 drinks □ 5 or 6 drinks □ 7 to 9 drinks □ 10 or more drinks	If "Yes", How often did you have 6 or more drinks on one occasion in the past year? □ Never □ Less than monthly □ Monthly □ Weekly □ Daily or almost daily

Do you smoke marijuana? __Yes __ No

Miscellaneous:

Caffeine

How many cups per day of coffee do you have?

□ None 1-2 □ 3-4 □ 4or more

Other caffeine

□ Chocolate
□ Soda
□ Pills

How much/how often:_____

Community Involvement

□ None
□ Religious group
□ Community organizations
□ Sports or recreational activities
□ Other, specify:

Domestic Violence

□ None
□ History in the past
□ Has restraining order
□ Feels unsafe at home
□ Has safety plan

Exercise

□ Yes No

How often:

□ Weekly
□ Daily
□ Occasionally

What type of exercise:_____

Housing	Home Smoke Detectors	Living with
	□ None	□ Alone
	□ Smoke Detectors	□ Spouse
Are you homeless?	□ Radon Detectors	□ Significant other
□ Yes	□ Carbon Monoxide Detector	□ Family
□ No		□ Friend(s)

Legal Problems: __ None __ On probation __ On parole __ Awaiting trial

Natural Support System	Other in the home	Pets	Travel outside United States
□ None	□ Parents	□ Cat(s)	□ None the last 6 month
□ Relies on family	□ Siblings	□ Dog(s)	□ Travels to South America
□ Relies on friends	□ Foster children	□ Birds	□ Travels to Europe
□ Relies on government assistance		□ Reptiles	□ Travels to Asia
□ Owns a home		□ Exotic animals	□ Travels to Africa

Household
Number of Adults in household:_____
Number of children in household:
Religion:
Family yearly income: _____

NORTH FLORIDA MEDICAL

PRAPARE SMART FORM

Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Check the box applicable to the answer for each question

1. What is your current housing situation?

   ☐ I have housing

   ☐ I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on beach, or in a park.

   ☐ I choose not to answer this question

2. Are you worried about losing your housing?
   ☐ Yes
   ☐ No
   ☐ I choose not to answer this question

3. What is the highest level of school you have finished?
   ☐ Less than a high school degree
   ☐ High School Diploma or GED
   ☐ More than High School
   ☐ I choose not to answer this question

4. What is your current work situation?
   ☐ Unemployed or seeking work
   ☐ Part Time or Temporary work
   ☐ Full Time work

   ☐ Otherwise unemployed but not seeking work

   (ex. Student, retired, disabled, unpaid primary care giver)

   ☐ I choose not to answer this question

5. In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? (Check all that apply)

   ☐ Food ☐ Child Care ☐ Other (please write in)

   ☐ Clothing ☐ Medicine or any health care (medical, dental, mental health or vision)

   ☐ Utilities ☐ Phone ☐ I do not have problems meeting my needs

   ☐ I choose not to answer this question

6. Has lack of transportation kept you from medical appointments, meetings, work or from getting things done in your daily living?
   - ☐ Yes, it has kept me from medical appointments or from getting my medications
   - ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things needed for daily living
   - ☐ No
   - ☐ I choose not to answer this question

7. How often do you see or talk to people that you care about and feel close to? (for example: talking to friends on the phone, visiting friends or family, going to church or club meetings)
   - ☐ Less than once a week
   - ☐ 1 or 2 times a week
   - ☐ 3 to 5 times a week
   - ☐ More than 5 times a week
   - ☐ I choose not to answer this question

8. How stressed are you? Stress is when someone feels tense, nervous, anxious, or cannot sleep at night because their mind is troubled.
   - ☐ Not at all
   - ☐ A little bit
   - ☐ Somewhat
   - ☐ Quite a bit
   - ☐ Very much
   - ☐ I choose not to answer this question

9. In the past year have you spent more than 2 nights in jail, prison, detention center, or juvenile correctional facility?
   - ☐ Yes
   - ☐ No
   - ☐ I choose not to answer this question

10. Are you a refugee?
   - ☐ Yes
   - ☐ No
   - ☐ I choose not to answer this question

11. What country are you from?
   - ☐ Unites States
   - ☐ Country other than United States (please write in)
   - ☐ I choose not to answer this question

12. Do you feel physically and emotionally safe where you currently live?
    - ☐ Yes
    - ☐ No
    - ☐ Unsure
    - ☐ I choose not to answer this question

13. In the past year, have you been afraid of your partner or ex-partner?
    - ☐ Yes
    - ☐ No
    - ☐ Unsure
    - ☐ I have not had a partner in the past year
    - ☐ I choose not to answer this question

Patient Name: _____

Patient DOB: _____

Consent for 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, diagnosis, 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 healthcare.

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 of 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:

_____ _____

Patient or Legal Guardian Signature Date

I object to uses and disclosures as follows:

UNIVERSAL PATIENT AUTHORIZATION FORM FOR FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND QUALITY OF CARE

****PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW****

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): _____

Date of Birth (mm/dd/yyyy): _____

Address: _____ City: _____ State: _____ Zip: _____

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure:

OF WHAT: **ALL MY HEALTH INFORMATION including any information about sensitive conditions** (if any) [See page 2 for details]

FROM WHOM: ALL information sources [See page 2 for details]

TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name: _____ Phone: (____) _____

Address: _____ Fax: (____) _____

PURPOSE: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission.

REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read all pages of this form and agree to the disclosures above from the types of sources listed**.

X_____ _____

Signature of Patient or Patient's Legal Representative — Date Signed (mm/dd/yyyy)

_____

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ☐ Parent of minor
- ☐ Guardian
- ☐ Other personal representative (explain: _____)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

Explanation of Form Florida AHCA FC4200-004
"Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"Of What": includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. **All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:**
    a. Drug, alcohol, or substance abuse
    b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
    c. Sickle cell anemia
    d. Birth control and family planning
    e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
    f. Genetic (inherited) diseases or tests
2. **Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.**
3. **Information created before or after the date of this form**.

"From Whom" includes: **All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom": For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

"Purpose": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

"Revocation": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses by giving written notice. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re-disclosure of Information": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.

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

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.

North Florida Medical Centers, Inc.
Notice of Information Practices

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.

Understanding Your Health Record Information

Each time you visit a hospital, a physician, or another health care provider, the provider makes a record of your visit. Typically, this record contains your health history, current symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment. This information, often referred to as your medical record, serves as the following:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care that you received.
- Means by which you or a third-party payer can verify that you actually received the services billed for.
- Tool in medical education.
- Source of information for public health officials charged with improving the health of the regions they serve.
- Tool to assess the appropriateness and quality of care that you received.
- Tool to improve the quality of health care and achieve better patient outcomes.

Understanding what is in your health records and how your health information is used helps you to--

- Ensure its accuracy and completeness.
- Understand who, what, where, why, and how others may access your health information.
- Make informed decisions about authorizing disclosure to others.
- Better understand the health information rights detailed below.

Your Rights under the Federal Privacy Standard

Although your health records are the physical property of the health care provider who completed it, you have the following rights with regard to the information contained therein:

- Request restriction on uses and disclosures of your health information for treatment, payment, and health care operations. "Health care operations" consist of activities that are necessary to carry out the operations of the provider, such as quality assurance and peer review. The right to request restriction does not extend to uses or disclosures permitted or required under the following sections of the federal privacy regulations: § 164.502(a)(2)(i) (disclosures to you), 164.510(a) (for facility directories, but note that you have the right to object to such uses), or 164.512 (uses and disclosures not requiring a consent or an authorization). The latter uses and disclosures include, for example, those required by law, such as mandatory communicable disease reporting. In those cases, you do not have a right to request restriction. The consent to use and disclose your individually identifiable health information provides the ability to request restriction. We do not, however, have to agree to the restriction. If we do, we will adhere to it unless you request otherwise or we give you advance notice. You may also ask us to communicate with you by alternate means, and if the method of communication is reasonable, we must

grant the alternate communication request. You may request restriction or alternate communications on the consent form for treatment, payment, and health care operations.

- Obtain a copy of this notice of information practices. Although we have posted a copy in a prominent location throughout the facility, you have a right to a hard copy upon request.
- Inspect and copy your health information upon request. Again, this right is not absolute. In certain situations, such as if access would cause harm, we can deny access. You do not have a right of access to the following:
    - Psychotherapy notes. Such notes consist of those notes that are recorded in any medium by a health care provider who is a mental health professional documenting or analyzing a conversation during a private, group, joint, or family counseling session and that are separated from the rest of your medical record.
    - Information compiled in reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings.
    - Protected health information ("PHI") that is subject to the Clinical Laboratory Improvement Amendments of 1988 ("CLIA"), 42 U.S.C. § 263a, to the extent that giving you access would be prohibited by law.
    - Information that was obtained from someone other than a health care provider under a promise of confidentiality and the requested access would be reasonably likely to reveal the source of the information.

  In other situations, we may deny you access, but if we do, we must provide you a review of our decision denying access. These "reviewable" grounds for denial include the following:
    - A licensed healthcare professional, such as your attending physician, has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of yourself or another person.
    - PHI makes reference to another person (other than a health care provider) and a licensed health care provider has determined, in the exercise of professional judgment, that the access is reasonably likely to cause substantial harm to such other person.
    - The request is made by your personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that giving access to such personal representative is reasonably likely to cause substantial harm to you or another person.

  For these reviewable grounds, another licensed professional must review the decision of the provider denying access within 60 days. If we deny you access, we will explain why and what your rights are, including how to seek review.

  If we grant access, we will tell you what, if anything, you have to do to get access. We reserve the right to charge a reasonable, cost-based fee for making copies.
- Request amendment/correction of your health information. We do not have to grant the request if the following conditions exist:
    - We did not create the record. If, as in the case of a consultation report from another provider, we did not create the record, we cannot know whether it is accurate or not. Thus, in such cases, you must seek amendment/correction from the party creating the record. If the party amends or corrects the record, we will put the corrected record into our records.
    - The records are not available to you as discussed immediately above.
    - The record is accurate and complete.

If we deny your request for amendment/correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we grant the request, we will make the correction and distribute the correction to those who need it and those whom you identify to us that you want to receive the corrected information.

- Obtain an accounting of nonroutine uses and disclosures, those other than for treatment, payment, and health care operations. We do not need to provide an accounting for the following disclosures:
    - To you for disclosures of protected health information to you.
    - For the facility directory or to persons involved in your care or for other notification purposes as provided in § 164.510 of the federal privacy regulations (uses and disclosures requiring an opportunity for the individual to agree or to object, including notification to family members, personal representatives, or other persons responsible for your care, of the your location, general condition, or death).
    - For national security or intelligence purposes under § 164.512(k)(2) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
    - To correctional institutions or law enforcement officials under § 164.512(k)(5) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
    - That occurred before April 14, 2003.

  We must provide the accounting within 60 days. The accounting must include the following information:
    - Date of each disclosure.
    - Name and address of the organization or person who received the protected health information.
    - Brief description of the information disclosed.
    - Brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure or, in lieu of such statement, a copy of your written authorization or a copy of the written request for disclosure.
- Revoke your consent or authorization to use or disclose health information except to the extent that we have taken action in reliance on the consent or authorization.
- Submit a complaint to NFMC and to HHS if you believe your privacy rights have been violated. You may contact NFMC's Privacy Officer at (850) 385-4494 to file a complaint. NFMC will not retaliate against individuals for filing a complaint.
- Disputes not resolved by the complaint procedure shall be resolved by binding arbitration in Tallahassee, Florida, under rules of The American Arbitration Association with each party to pay its own attorney fees.

Our Responsibilities under the Federal Privacy Standard

In addition to providing you your rights, as detailed above, the federal privacy standard requires us to take the following measures:

- Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.
- Provide you this notice as to our legal duties and privacy practices with respect to individually identifiable health information that we collect and maintain about you.
- Abide by the terms of this notice.
- Train our personnel concerning privacy and confidentiality.

- Implement a sanction policy to discipline those who breach privacy/ confidentiality or our policies with regard thereto.
- Mitigate (lessen the harm of) any breach of privacy/confidentiality.

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law.

How to Get More Information or to Report a Problem

If you have questions and/or would like additional information, you may contact Privacy Officer or the Chief Executive Officer at 850-385-4494.

Examples of Disclosures for Treatment, Payment, and Health Operations

- *If you give us consent, we will use your health information for treatment.*

Example: A physician, a physician's assistant, a therapist or a counselor, a nurse, or another member of your health care team will record information in your record to diagnose your condition and determine the best course of treatment for you. The primary caregiver will give treatment orders and document what he or she expects other members of the health care team to do to treat you. Those other members will then document the actions they took and their observations. In that way, the primary caregiver will know how you are responding to treatment. We will also provide your physician, other health care professionals, or a subsequent health care provider copies of your records to assist them in treating you once we are no longer treating you.

- *If you give us consent, we will use your health information for payment.*

Example: We may send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatment received, and supplies used.

- *If you give us consent, we will use your health information for health operations.*

Example: Members of the medical staff, the risk or quality improvement manager, or members of the quality assurance team may use information in your health record to assess the care and outcomes in your cases and the competence of the caregivers. We will use this information in an effort to continually improve the quality and effectiveness of the health care and services that we provide.

- *Business associates:* We provide some services through contracts with business associates. Examples include certain diagnostic tests, a copy service to make copies of medical records, and the like. When we use these services, we may disclose your health information to the business associates so that they can perform the function(s) that we have contracted with them to do and bill you or your third-party payer for services provided. To protect your health information, however, we require the business associates to appropriately safeguard your information.
- *Directory:* Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.
- *Notification:* We may use or disclose information to notify or assist in notifying a family member, a personal representative, or another person responsible for your care, your location, and general condition.
- *Communication with family:* Unless you object, health professionals, using their best judgment, may disclose to a family member, another relative, a close personal friend, or any other person that you identify health information relevant to that person's involvement in your care or payment related to your care.
- *Research:* We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

- *Funeral directors:* We may disclose health information to funeral directors consistent with applicable law to enable them to carry out their duties.
- *Marketing/continuity of care:* We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- *Fundraising:* We may contact you as a part of a fundraising effort. You have the right to request not to receive subsequent fundraising materials.
- *Food and Drug Administration ("FDA"):* We may disclose to the FDA health information relative to adverse effects/events with respect to food, drugs, supplements, product or product defects, or postmarketing surveillance information to enable product recalls, repairs, or replacement.
- *Workers compensation:* We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- *Public health:* As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- *Correctional institution:* If you are an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.
- *Law enforcement:* We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
- *Health oversight agencies and public health authorities:* If a member of our work force or a business associate believes in good faith that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public, they may disclose your health information to health oversight agencies and/or public health authorities, such as the department of health.
- *The federal Department of Health and Human Services ("DHHS"):* Under the privacy standards, we must disclose your health information to DHHS as necessary to determine our compliance with those standards.

Effective date: April 14, 2003
Revised April 1, 2017

Lane M. Lunn, CEO
North Florida Medical Centers, Inc.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION THAT WE MAINTAIN. IF WE CHANGE OUR INFORMATION PRACTICES, WE WILL POST THE NEW NOTICE IN THE MEDICAL CENTER.

Today's Date: _____

NFMC

North Florida Medical Centers, Inc.

Coronavirus Disease (COVID-19) Screening Questionnaire REVISED 07/14/2020

Patient Name: _____ Patient Date of Birth: _____

Please answer the following:

1. Have you had any of the following:

   Cough YES _____ NO _____

   Shortness of breath or difficulty breathing? YES _____ NO _____

   AND

2. Have you had any of the following?

   Fever* in the last 48 hours YES _____ NO _____

   Chills YES _____ NO _____

   Repeated shaking with chills YES _____ NO _____

   Muscle or body aches YES _____ NO _____

   Headache YES _____ NO _____

   Sore throat YES _____ NO _____

   New loss of taste and smell YES _____ NO _____

   Congestion or runny nose YES _____ NO _____

   Fatigue YES _____ NO _____

   Diarrhea YES _____ NO _____

   Nausea YES _____ NO _____

3. Have you been tested for COVID-19 in the last month? YES _____ NO _____

4. Have you been exposed to someone diagnosed with COVID-19 in the last month?
   YES _____ NO _____

*confirmed or not confirmed

Written 02/04/2020; Revised 03/04/2020; Revised 03/18/2020; Revised 04/07/2020; 04/28/2020; 06/30/2020. 07/14/2020