# PATIENT INFORMATION

Patient Name ______________________ Date of Birth ____________ Gender: ☐ Male ☐ Female

Social Security # ____________________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Address ____________________ City ______________ State ______ Zip __________

Home Phone__________ Cell Phone ____________ Email Address____________________
May we leave messages at your home: ☐ Yes ☐ No

Employer Name______________ Address____________________ Phone__________
May we contact you at work: ☐ Yes ☐ No **Are you a veteran?** ☐ Yes ☐ No

Race: ☐ Asian ☐ American Indian ☐ Black ☐ Caucasian ☐ Haitian/Black ☐ Haitian/White ☐ Hispanic ☐ Native Hawaiian ☐ More than one Race ☐ Unreported/Unknown

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino Language: ☐ English ☐ Spanish ☐ French/Creole ☐ Other________

How did you hear about WFHC: ________________________________________

Would you like to enroll in the Follow My Health Patient Portal? ☐ Yes ☐ No

**Emergency Contact**______________ Phone __________ Relation to Patient __________

## SPOUSE / PARTNER / PARENT / GUARDIAN INFORMATION

Name____________________ Birth date____________ Social Security #____________

Address____________________ City__________ State___ Zip ______Phone__________

Relation to Patient __________Employer____________________Phone____________

Name____________________ Birth date____________ Social Security #____________

Address____________________ City__________ State___ Zip ______Phone__________

Relation to Patient __________Employer____________________Phone____________

## PATIENT INSURANCE COVERAGE

Primary Insurance ____________________ Group/ID #____________Policy Holder __________

Secondary Insurance____________________ Group/ID #____________Policy Holder __________

**DOES PATIENT HAVE MEDICAID OR MEDICARE COVERAGE?** ☐ Yes ☐ No ***(If yes, please give # below)***

Medicaid #: ____________________ Medicare #: ____________________

**IS PATIENT SELF-PAY?** ☐ Yes ☐ No (***A sliding fee scale is available to all qualifying self-pay patients***.)

**I hereby authorize the release of any medical or behavioral health information necessary to process insurance. I also authorize insurance benefits to be paid directly to Whole Family Health Center, 725 N US Highway 1, Fort Pierce, FL 34950. I understand that if my insurance does not pay, I am responsible for payment of services provided.**

Signature: ______________________________ Date: ____________

Print Name: ______________________________ Relationship: ____________

*Reason Patient Unable to Sign: ☐ Minor ☐ Incompetent ☐ Deceased*

whole family health center

725 N US Highway 1, Fort Pierce, FL 34950
Phone: 772.468.9900 Fax: 772.468.2364

981 37th Place, Vero Beach, FL 32960
Phone: 772.257.5785 Fax: 772.257.5325

# CONSENT FOR TREATMENT

Patient Name: ________________________________________________ Date of Birth: ________________

☐ Adult ☐ Minor

I hereby consent to receive medical and/or behavioral health services at Whole Family Health Center. I agree to play an active role in my treatment plan.

- I am freely choosing to enter into treatment, and I understand that I may discontinue treatment at any time.
- I understand that no promises have been made to me as the results of treatment or any procedures provided by WFHC's medical personnel.
- I understand and consent to having any treatment received be made a part of my Whole Family Health Center medical records.
- I give my consent for WFHC to refer me for diagnostic and treatment services.
- I understand that WFHC supports the education of medical professionals and maintains Residents and Students that may assist in relation to care.

☐ I authorize the following person(s) to receive information or to make inquiries concerning the patient's healthcare.

Name: ___________________________________ Relationship: ________________Phone:________________

Name: ___________________________________ Relationship: ________________Phone:________________

☐ I do not authorize anyone to receive information or to make inquiries concerning the patient's healthcare.

Signature: ________________________________________________________ Date: ____________________

Print Name: ___________________________________________________ Relationship: __________________

*Reason Patient Unable to Sign: ☐ Minor ☐ Incompetent ☐ Deceased*

**PATIENT RIGHTS AND RESPONSIBILITIES STATEMENT**

Whole Family Health Center (WFHC) encourages patients and their families to report concerns related to treatment services and patient safety issues to any of our staff. WFHC is committed to ensuring that the following rights and responsibilities are preserved for all patients.

AS A PATIENT AT WFHC, YOU HAVE THE **RIGHT** TO:

1. Respectful care and treatment by competent personnel, regardless of the patient's age, race, religion, sex, disability, educational level or payment source.
2. A prompt and reasonable response to questions and requests.
3. Know what patient support and advocacy services are available including counseling on the availability of known financial resources for care.
4. Privacy concerning his/her own medical and behavioral health care program. Case discussion, consultation, examination and treatment are considered confidential and shall be conducted discreetly.
5. Access to your medical records.
6. Refuse any treatment, except as otherwise provided by law as well as the right to make decisions regarding end of life care.
7. Receive, prior to treatment, a reasonable estimate of charges for medical and behavioral health care.
8. Receive a copy of an understandable itemized bill and if necessary, to have the charges explained.
9. Be given complete and current information about the diagnosis, treatment and prognosis, including information about alternative treatments and possible complications. When it is not medically advisable to give the information to the patient, the information shall be given on his/her behalf to the responsible person.
10. Have access to an interpreter whenever necessary.
11. Right to express grievances and voice complaints without recrimination. Have grievances and complaints reviewed and resolved.

AS A PATIENT AT WFHC, YOU ARE **RESPONSIBLE** TO:

1. Be respectful and honest to providers and staff.
2. Comply with treatment plans and make decisions responsibly, without putting others at risk.
3. Report fraud and wrong doing.
4. Bring the appropriate insurance card with you to each appointment with a minimum payment as expected.
5. Attempt to bring another adult to supervise if you need to bring small children with you to your appointment.
6. Bring a list of ALL medications with you to every appointment including prescriptions, over-the-counter medications, and herbal supplements.
7. Bring a current immunization record with you if your child is scheduled for a physical or immunizations.
8. Allow at least 5 days for completion of insurance forms and disability forms. Allow 30 days to receive copies of medical records.
9. Please give 24 hour notice when canceling or rescheduling appointments. Arrive 10 minutes early for your scheduled appointment in case records need to be updated. If you are late, we may not be able to see you.
10. If you have not been seen by one of our providers in three (3) years you will be considered a new patient.
11. Smoking is NOT allowed on WFHC property.

I, as a patient of Whole Family Health Center, agree to the above patient rights and responsibilities.

Signature: ______________________________ Date: ________________

Print Name: ______________________________ Relationship: ________________

*Reason Patient Unable to Sign: ☐ Minor ☐ Incompetent ☐ Deceased*

whole family health center
725 N US Highway 1, Fort Pierce, FL 34950
Phone: 772.468.9900 Fax: 772.468.2364
981 37th Place, Vero Beach, FL 32960
Phone: 772.257.5785 Fax: 772.257.5325

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

## PATIENT INFORMATION:

PATIENT NAME: ______________________________________________
LAST FIRST MI MAIDEN OR OTHER

DATE OF BIRTH ____________ SOCIAL SECURITY NUMBER ____________ MEDICAL RECORD # ____________

ADDRESS ____________ CITY/STATE ____________ ZIP CODE ____________

## INFORMATION RELEASED FROM:

NAME ______________________________

ADDRESS ______________________________

CITY/STATE/ZIP ______________________________

Fax #: ______________________________

## INFORMATION RELEASED TO:

**Whole Family Health Center**
NAME

☐ **725 N US Highway 1, Fort Pierce FL 34950**
**Ph: (772) 468-9900 Fax: (772) 468-2364**

☐ **981 37th Place, Vero Beach FL 32960**
**Ph: (772) 257-5785 Fax: (772) 257-5325**

## INFORMATION TO BE RELEASED OR INSPECTED: (Check all applicable categories.)

____ Entire Chart/Record, including, but not limited to, all of the following:

__ Immunization Record
__ Discharge Summary
__ History & Physical
__ Operative Reports
__ Pap Smear Reports
__ Pathology Reports
__ Hepatitis Serology
__ All CD4 & Viral Load Results
__ Health Maintenance Record
__ Record of Treatment for STI

__ X-ray and Other Radiology Reports
__ Laboratory Reports
__ Antiretroviral Treatment History
__ Treatment for Hepatitis B or C
__ Initial Office Visit Notes
__ Last 2 Office Visit Notes
__ Problem List
__ Workers' Compensation
__ All Genotypes/Phenotypes
__ Proof of Negative PPD or TB Treatment

__ Assessment/ Bio-Psychosocial Results
__ Billing and Patient Account Records
__ Positive Western Blot
__ Copies of Reports Originating from Other Providers
__ Mental Health/Alcohol or Drug Abuse Treatment/Attendance
__ Social Services Reports and/or Evaluations

__ Other: ______________________________________________

**REASON FOR DISCLOSURE: Continuation of medical or behavioral health care.**

**This authorization will remain in effect for one (1) year and will be effective for medical records generated up to the expiration date of the consent. I understand that:**

1. I have a right to revoke this authorization, except to the extent that information has already been released in response to this authorization;
2. I may inspect and receive a copy of the disclosed information upon payment of a reasonable fee.
3. These records may contain information including psychological, psychiatric, substance abuse/alcohol abuse, HIV/AIDS results, testing and/or progress notes.

**A FAX copy/photocopy of this authorization shall be considered as valid as the original.**

Signature: ______________________________ Date: ____________

Print Name: ______________________________ Relationship: ____________

*Reason Patient Unable to Sign: ☐ Minor ☐ Incompetent ☐ Deceased*

# RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: ______________________________________________ Date of Birth: __________________
(Please Print)

I understand that as part of my healthcare, Whole Family Health Center originates and maintains health records describing my health history, symptoms, examination, test results, diagnoses, treatment and any plans of future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment as well as providing communication among all the healthcare professionals involved in my care. **(Treatment)**
- Sources of information in the application of charges to my account as well as a means by which my insurer can verify that the services billed were actually provided to me. **(Payment)**
- A tool for use in healthcare operations such as assessing the quality of care I have received, the competence of healthcare professionals involved in my care and all other office operations meant to facilitate the efficient rendering of my care. **(Operations)**

For the purposes stated above, I hereby authorize Whole Family Health Center to release any and all records and written material of any nature whatsoever, pertaining to my care. This includes: office records and test results, hospitalizations and related records, reports, consultations, pathology slides and reports, emergency room records, memoranda and details of any charges for services rendered at any time to myself or child. This consent specifically includes consent for the release of any psychological and/or psychiatric records, records relating to the treatment of sexually transmitted diseases and records relating to any treatment for my HIV or AIDS status.

I acknowledge receipt of Whole Family Health Center Notice of Privacy Practices and understand I have the opportunity to request clarification of any portion of the notice that is unclear to me. I understand that Whole Family Health Center has the right to change their "Notice" and, prior to implementation, mail a copy of the revised notice to me at the address I have provided.

I understand that I have the right to request restrictions regarding how my Protected Health Information may be used or disclosed to carry out **Treatment, Payment** or **Operations** and that the practice is not required to comply with the restrictions requested. I authorize or restrict the release of information pursuant to the following:

## NO RESTRICTIONS

☐ I request no restrictions.

## RESTRICTIONS:

☐ I request the following restrictions to the use or disclosure of my health information:

______________________________________________________________________

______________________________________________________________________

I understand I have the right to revoke this consent in writing, except to the extent that Whole Family Health Center has already taken action in reliance thereon.

Signature: __________________________________________________________ Date: ____________

Print Name: ______________________________________________ Relationship: __________________

*Reason Patient Unable to Sign:* ☐ *Minor* ☐ *Incompetent* ☐ *Deceased*