Sign-in Time:_____

I have received a copy of the Notice of Privacy Practices True Health.

_____
Signature of Patient/Patient Representative

_____
Date

_____
Relationship of Patient Representative to Patient

☐ SANFORD HEALTH CENTER ☐ ALAFAYA HEALTH CENTER ☐ HOFFNER HEALTH CENTER ☐ CASSELBERRY HEALTH CENTER

☐ LAKE UNDERHILL HEALTH CENTER ☐ SOUTHSIDE HEALTH CENTER ☐ AIRPORT HEALTH CENTER

☐ CHENEY WELLNESS COTTAGE ☐ EVANS WELLNESS COTTAGE

Adults

Date _____

Please print

New Patient ☐ Yes ☐ No Patients Name:	Birth Date:	Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐
Mailing Address: Apt. #	Male ☐ Female ☐	
City: State: Zip:	Home Phone: Cell Phone:	
Patient's Social Security Number:	Driver's License Number:	

Do you have any type of health care coverage? _____ Are you a veteran? _____ Are you Hispanic	☐ Yes _____ ☐ Yes _____ ☐ Yes	☐ No _____ ☐ No _____ ☐ No	☐ Medicare _____	☐ Medicaid ☐ Private Insurance _____

Ethnic Group:

☐ Asian	☐ Black/African American (including American Indians or Alaska Natives of Latino/Hispanic Descent)	☐ White including Whites of Latino/Hispanic Descent)	☐ More than one race	☐ Unreported / Refused to report	☐ Native Hawaiian ☐ Other Pacific Islander

Language Preference:

Occupation:	Employer:
Email Address:	
In case of emergency, contact name:	Emergency contact Phone Number:
Patient/Guardian Signature:	Date:

UNINSURED SLIDING SCALE FEE SCHEDULE

Income Assessment Worksheet

Please list income for all dependent family members. This does not include guests, roommates, or non-dependent family members.

Source	Amount	Weekly	Bi-Wkly	Monthly	Annually
Salaries and Wages (Self)	_____	☐	☐	☐	☐
Salaries and Wages (Spouse)	_____	☐	☐	☐	☐
Pension Plan/IRA/Keogh Plan	_____	☐	☐	☐	☐
Workman's Comp (SSI)	_____	☐	☐	☐	☐
Social Security (Self/Spouse)	_____	☐	☐	☐	☐
Social Security (Children)	_____	☐	☐	☐	☐
SSI (Supplemental Security)	_____	☐	☐	☐	☐
Child Support/Alimony	_____	☐	☐	☐	☐
Tip Income (Documented)	_____	☐	☐	☐	☐
Unemployment Benefits	_____	☐	☐	☐	☐
Notarized Letter	_____	☐	☐	☐	☐
Number of Dependents	_____				
Proof of Income Presented	_____				
No proof of income presented	_____	☐			

Demo Clerk Initials: _____

Date: _____

True Health reserves the right to inspect your tax return and/or wage statement for previous periods upon request. Eligibility will be updated on an annual basis. If there are any changes in your income status prior to your annual update, please notify True Health immediately.

Sliding Fee Scale Patients Must Read and Sign the Following:

I have been informed and understand that if I do not supply proof of my income at my next visit my category will be changed to a higher fee scale.

_____ _____

Patient/Guardian Name (Print) Patient/Guardian Signature

For Official Use Only

Your documented annual income is $_____. Your documented family size is ____. Therefore, you qualify for _____ discount until _____.

_____ _____

Demographics Clerk Date

I hereby certify that the income and family information supplied in the above tables is true and correct to the best of my knowledge. I understand this document will be maintained in my permanent medical record and that falsification of information may constitute a federal offense.

_____ _____

Patient/Guardian Signature Date

True Health

Consent for treatment

I hereby give permission for the medical facility True Health to treat and prescribe medications, as they feel necessary on me, my child, children, or spouse. I, as a parent, legal guardian or responsible adult, must accompany all children to the center and stay with them throughout the entire examination.
Under penalties of perjury, I declare the information contained to be true and correct, and consent to verification by True Health, and authorize True Health to release information to insurance company in order that direct payment can be made to the above institution on my behalf. I herby agree and covenant that in consideration for the treatment of me or my child, children, spouse I will pay for the cost of treatment.

Patient signature: _____ Date: _____

Relationship to patient: _____

Witness: _____Date:_____

Assignment of Benefits

I recognize and accept full personal responsibility for all professional services rendered and further authorize release of information for direct insurance payment to True Health. I authorize the release of medical information to process all insurance claims.

Patient Signature: _____

Medicaid Release Information

I certify that I am a recipient of Medicaid Program and request payment and authorized benefits be made on my behalf. I authorize the center and center insurance carrier to make available to the Florida Division of Family Services and requested information concerning medical insurance and financial records relating to my medical care. I herby certify all insurance shall be assigned to the center where services are provided.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Medicare Lifetime Authorization

I request that payment of Authorized Medicare benefits be made to either me or on my behalf for the services furnished to me by True Health. I authorize any holder of medical or other information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

Patient Signature: _____Date:_____

Witness: _____Date:_____

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of your Protected Health Information
Your protected health information (PHI) will be used by True Health (including our in-house pharmacy) or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use of Disclosure of Your Protected Health Information
You may request a restriction on the use or disclosure of your PHI. True Health may or may not agree to restrict the use or disclosure of your PHI. If True Health agrees to your request, the restriction will be binding on the practice. Use or disclosure of PHI in violation of an agreed upon restriction will be a violation of the Federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
True Health reserves the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed this consent form and I give my permission to True Health to use and disclose my health information in accordance with it.

☐ Approve ☐ Refuse

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

_____ _____
Signature of Patient Representative Date

_____
Patient Representative Relationship to Patient

REQUEST TO RESTRICT PROTECTED HEALTH INFORMATION ACCESS

I would like to restrict the use or disclosure of my protected health information (PHI) to the following individuals (Please write the name(s) of the individuals that may access your PHI):

_____

_____

_____

_____

_____

NOTE: This request will not restrict the normal use or disclosure of your PHI necessary by True Health (including our in-house pharmacy) for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Amendment to Restriction: You may amend your request for restriction of the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

_____ _____
Signature of Patient Representative Date

_____
Patient Representative Relationship to Patient

True Health
Patient's Bill of Rights and Responsibilities

True Health recognizes the importance of and believes that the "Patient's Bill of Rights and Responsibilities" will contribute to a more effective patient care. This Bill of Rights and Responsibilities recognizes that the service providers and clinic facility staff have certain responsibilities toward the patient. It is further recognized that the patient has certain specific rights and responsibilities. It is the purpose of this statement to delineate these in a document for Public Record.

Patient's rights:

1. Information disclosure: Consumers have the right to receive accurate and easily understood information to make informed decisions about their health plans and medical providers. Consumers have the right to be informed on services available and their respective fees and related charges for services not covered for which the patient will be responsible. Consumers have the right to be informed on the accreditation status of the center, certification and years of practice of the medical providers, results of consumer satisfaction surveys and quality of care studies, and complaint and appeal processes. Consumers have the right to be informed about the organization's rules and regulations that apply to them. Consumers have the right to be informed of any existing or potential relationship between this organization and other health or educational agencies or individuals participating in your health care.

2. Choice of providers and plans: Consumers have the right to choose a health care provider within our organization to assure access to high quality medical care. Consumers have the right to access qualified specialists through our referral network. Consumers have the right to choose health plans within our panel.

3. Access to emergency services: Consumers have the right to access emergency services when and where the need arises. The center will inform consumers of the provisions for after hour's access to the medical providers and emergency coverage.

4. Participation in treatment decisions: Consumers have the right to be fully informed by their medical provider of the diagnosis, treatment, and prognosis in simple terms that can be understood, and to be offered the opportunity to participate in the planning of their medical treatment and any required specialist referrals, and to refuse to participate in experimental research. Consumers have the right to be fully informed and enabled to give informed consent prior to procedures.

5. Respect and Non discrimination: Consumers have the right to be treated with consideration, respect and full recognition of their dignity and individuality and to be free from mental and physical abuse, and free from physical restraints (except in emergencies) except as authorized in writing by a medical provider for a specified and limited period of time, or when necessary to protect the patient from injury to themselves or to others. Consumers have the right to receive the best available medical care regardless of age, sex, race, color, religion, language, economic status, disability, or national origin.

6. Confidentiality: Consumers have the right to have privacy and confidentiality in all interactions and conversations with staff members and in their medical records. Medical records may only be released to other individuals or organizations with the patient's consent, except in cases required by law or third party payment contracts.

7. Complaints and Appeals: Consumers have the right to a fair and efficient process for resolving differences with their medical providers or members of our staff free from restraint, interference, coercion, discrimination or reprisal. Complaints may be presented in person or in writing. If the complaint is clinical in nature, it will be handled by the Nursing Supervisor on site. If the complaint is concerning the pharmacy, it will be handled by the Pharmacist in charge. If the complaint concerns the clerical or demographic staff, it will be handled by the Site Supervisor. A follow-up response will be given to the patient in a timely manner, either in person, via phone, or written communication.

8. You have the right to receive information to assist you in preparing a document called an "Advance Directive." You have a right to have this information included in the electronic health record and it will also be included in any appropriate record releases as per patient's signed consent. True Health does not honor DNR (Do Not Resuscitate) Orders.

Patient's responsibilities:

1. Patients have the responsibility to follow the organization's rules and regulations.
2. Patients have the responsibility to report any changes in their medical condition.
3. Patients have the responsibility to let their medical provider know if they do not understand any aspect of their medical care.
4. Patients have the responsibility to participate in the decision making processes regarding their medical care and to follow the treatment plans set up for them, including keeping appointments or notifying in advance when unable to keep them.
5. Patients have the responsibility to give truthful financial information, and to pay their bills in a timely manner.
6. Patients have the responsibility to advise us if they are dissatisfied with their care.
7. Patients have the responsibility to treat other patients and our staff with respect, consideration, and full recognition of their dignity and individuality.
8. Patients have the responsibility to respect and care for the property and facilities at your service.

True Health reserves the right to refuse services to any patient who doesn't fulfill the patient's responsibilities.
Latrice Stewart, CEO

Patient/Guarantor Signature_____Date_____

Revised 11/25/2015

True Health
Financial Policy

Financial Policy
We hope that you will recognize that our financial policy is necessary part of assuming the resources required to maintain this health care service for our patients and for the community.
Charges for medical services are due and payable at the time services are rendered. We accept Visa, MasterCard, Discover, American Express, as well as personal checks, money orders, and cash.
In order to bill your insurance company for your health care costs, it is extremely important that we obtain complete information about your primary and supplement insurance companies, including phone numbers, addresses, and a copy of your insurance card. If this information is not provided, you will be required to pay any charges in full at the time of service. We will also use the information you provide to help with the preauthorization process. Even though we bill your insurance company for you, we still collect the co-pays and deductibles from you at the time of service.

Slide Fee Program:
In order to qualify for reduced rate services known as our slide fee program, which is based on income, we need the following; Income verification (last 3 check stubs, unemployment document stating amount received from unemployment, notarized letter, or previous year's tax return) photo ID, pediatric patients are required to bring proof of guardianship. If patient is unable to supply proof of income or has no income, a self declaration is available. The Center Manager will counsel with the patient before using the form to determine patient eligibility. All New qualified slide fee patients will be required to pay minimum fees (approx. $20.00) prior to services being rendered. If the patient fails to produce the required documents to qualify for the reduced services according to the federal guidelines, the patient will be considered self pay and will be asked to pay $118.00 prior to being seen by a provider.

Medicaid:
We accept assignment from Medicaid, so all payments from Medicaid will be made directly to the doctor. We bill Medicaid directly.

Medicare:
We accept assignment from Medicare, so all payment from Medicare will be made directly to True Health. We bill Medicare and supplement insurance directly. Due to FQHC rates the Medicare deductible is reduced for services obtained at our facilities.

Contracted Insurance:
We directly contract through the various physicians employed by our organization to provide service for our patients. If you are enrolled in one of these companies, you will pay the co-pay and deductible fees that are predetermined by your insurance carrier. You will be asked to pay any co-pays, deductibles, and co-insurance at the time of service. Some services may be deemed non-covered or medically unnecessary by your insurance company. If so, you are directly responsible for the charges incurred. Any balance that remains unpaid after the insurance payment is made is due to our office within 60 days.

Auto Accident and Workman's Comp:
Cases are not accepted at any of our facilities. Please contact your insurance carrier for referral for either of these services.

Non-Contracted Insurance:
Patients who have policies with non-contracted insurance companies will be responsible for all office visits at the time of service is rendered. You will be responsible for payment of all fees. Our fees are calculated based on the Medicare fee schedule.

We will work with patients in any way we can to ensure that their medical care is the finest available and that this care does not become a financial burden. Please sign and date the form, acknowledging that you have read and understood our financial policy.

Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____