Central Florida Health Care

REGISTRATION FORM

Last Name:_____ First Name:_____Middle: ____

Address:_____City:_____State:_____Zip: _____

Home Phone:_____Cell Phone:_____Work Phone: _____

Date of Birth:_____SS #: _____ Email:_____

Language Preferred:_____Marital Status: _____

Primary Care Provider:_____Referred by: _____

Insurance:_____Primary Insurance Holder: _____

Policy #:_____Group #: _____

Have you recently been hospitalized? Yes No If yes, where? _____

Do you use CFHC as your Pharmacy? Yes No If No, what pharmacy do you use? _____

Race:
___American Indian/Alaska Native
___ Asian
___ Black/African American
___ Native Hawaiian
___ Other Pacific Islander
___ White
___ More than 1 race
___ Prefer not to say

Total Number in Household: _____
Household Annual Income: _____
OR choose____A____B____C____D (See Flip Cards to choose)

Ethnicity:
___Hispanic/Latino
___Non-Hispanic/Latino
___Prefer not to say

Sexual Orientation:
___ Lesbian or Gay
___ Straight (not lesbian or gay)
___Bisexual
___ Something else
___Don't know
___ Choose not to disclose

Gender Identity:
___ Male
___ Female
___ Transgender Male/ female-to-Male
___ Transgender Female/Male-to-Female
___ Other
___ Choose not to disclose

Are you an agricultural worker? ____Yes ____No If yes are you___Seasonal OR___Migrant

Do you use Public Housing? ____Yes ____No

Are you homeless? ____Yes ____No

If you are homeless, where do you stay?_____Shelter_____Transitional_____Double up_____Street_____Other

Emergency Contact Name:_____Phone: _____

Relationship: _____

Revised 2/27/20

Central Florida Health Care

PLEASE INITIAL EACH SECTION

Patient Name:_____ **Date of Birth** _____

_____ I hereby give consent for medical evaluation and treatment including medication and vaccine history of myself, my child, or the person for whom I have guardianship. This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By initialing and signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

_____ I hereby assign my insurance benefits to be paid directly to the healthcare provider, Central Florida Health Care, Inc.

_____ I authorize Central Florida Health Care, Inc. to obtain/have access to my medication history.

_____ I authorize my provider's office to contact me by mobile phone by text.

_____ I authorize my provider's office to contact me by leaving a message on my phone.

_____ I have reviewed the Notice of Privacy Practices and have been given the opportunity to receive a copy.

PERMISSION for Providing Care:

I authorize an alternate decision maker to consent to, and be involved in, the medical or dental visit and care of my child or person for whom I am the guardian:

Alternate Person:_____ Relationship: _____

Number I can be reached at for questions: _____

PERMISSION of Information:

I give permission for Central Florida Health Care, Inc. to release information to the following person regarding my or this patient's protected health information for which I am the guardian. This information includes appointments, treatments, plans of care, billing information, etc.

Name of Person to release information to: _____

Relationship: _____

_____ _____

Patient/Guardian Printed Name Patient/Guardian Signature

_____ _____

Employee Witness Printed Name Employee Witness Signature

Date Form Completed and All Consents Signed: _____

Central Florida Health Care

RELEASE OF BILLING INFORMATION
PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Method of Payment (Check all that apply)

☐ **Self-Pay**
- I wish to be considered for sliding fee scale. I have no Health/Dental Insurance coverage of any kind or my Health/Dental Insurance does not recognize Central Florida Health Care, Inc. as a participating provider. I shall authorize Central Florida Health Care, Inc. to verify my income with my employer. I understand that written proof of income is required.

☐ **Insurance**
- I am currently covered by Health/Dental Insurance. I understand that if I am no longer covered by Health/Dental Insurance I may be considered for sliding fee scale.

☐ **Medicaid**
- I am currently covered by Medicaid. I understand that if I am no longer considered Medicaid eligible I may apply for sliding fee scale if I have no other Health/Dental Insurance. I authorize Central Florida Health Care, Inc. to verify my income with my employer.

☐ **Medicare**
- I am currently on Medicare. If I currently do not have secondary coverage to Medicare I wish to be considered for sliding fee scale as a secondary. I authorize Central Florida Health Care, Inc. to verify my income with my employer.

☐ **Other** *(Please specify):* _____

☐ **I do not wish to be considered for the sliding fee scale.**
- I have been informed of the Sliding Fee Scale Discount offered by Central Florida Health Care, Inc. and have elected not to participate in this discount. I have seven (7) business days from my visit to bring in financial documentation to apply for sliding fee discount if I later decide to apply for a discount.

****

I,_____, the guarantor, agree to be personally and fully responsible for the payment of any and all medical services, not covered by a federal, state or commercial benefit program that are provided by Central Florida Health Care, Inc.

In the event that I have Health/Dental Insurance coverage, I authorize the release of any medical/dental or other information necessary in order for Central Florida Health Care, Inc. to process any insurance claims as a result of treatment. I will authorize the payment of medical/dental benefits to Central Florida Health Care, Inc. for any services provided while a patient at Central Florida Health Care, Inc.

I understand that I am personally and fully responsible for the payment of all applicable co-payments and deductible or, if applicable, the payment of the appropriate sliding fee. I understand that all applicable payments are due at the time of services.

I understand that in the event that I am unable to pay at the time of service or in the event of an outstanding balance, I will be required to speak to a financial counselor prior to services being rendered. I further understand that in order to remain a patient(s) in good standing, I may be required to sign a payment agreement.

_____ _____ _____ _____

Signature of Patient or Guarantor Date

_____ _____

Relationship to Patient

Central Florida Health Care

VERIFYING MIGRATORY AND SEASONAL AGRICULTURAL WORKER STATUS

The following questions are used to determine whether you or a family member are agricultural workers, and if you/they are considered seasonal (stay in one area all year long) or migratory. The four questions below are in alignment with the Public Health Service definitions of "Migrant", "Seasonal", "Aged or Disabled" farmworkers and agricultural employment.

Please circle "Yes" or "No"

CURRENT	
1. Have you or a member of your family with whom you reside **ever** done agricultural work as your principle employment? NOTE: Agricultural work includes: • Preparing, irrigating or spraying the fields, nurseries, orchards; • Planting, picking, sorting, packing or transporting fruits, vegetables, grains, nuts, plants, tobacco, hops, flowers, grass, alfalfa, hay or other agricultural products; • Planting trees; work with Christmas trees; picking pine needles or Spanish moss; • Working on farms that produce chickens, ducks, turkeys, cows, goats, sheep, horses, fish, seafood, etc.	**Yes** – If yes patient and his/her family are agricultural workers. Continue to questions 3 & 4 **No** – There is no current agricultural worker in the household. Continue to question 2
FORMER	
2. Have you or a family member with whom you reside stopped working in agriculture because or disability or old age?	**Yes** – If yes patient and his/her family can be classified as **Migratory workers** **No** – There is no current or former agricultural workers in the household. **STOP**
MIGRATORY	
3. In the past two years, have you or a family member with whom you reside established a temporary home in order to work in agriculture?	**Yes** – If yes patient and his/her family are **Migratory workers.** **STOP** **No** – Please continue to question 4
SEASONAL	
4. In the past two years, have you or a family member with whom you reside worked in agriculture on a seasonal basis without the need to establish a temporary home?	**Yes** – If yes patient and his/her family are **Seasonal workers.** **STOP**

Central Florida Health Care

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_____ _____ _____ _____

Signature of Patient or Guarantor Date

_____ _____

Relationship to Patient

Central Florida Health Care

NO SHOW APPOINTMENT & LATE ARRIVAL AGREEMENT
FOR MEDICAL AND DENTAL APPOINTMENTS

To make sure all patients receive the best healthcare possible, it is important that you come to your appointment. Central Florida Health Care (CFHC) helps you remember your appointment by calling you two days ahead. Central Florida Health Care understands that sometimes you have to miss an appointment. If this happens, please call CFHC as soon as possible.

1) If you cannot keep your appointment, please cancel it within 24 hours. This will allow other patients to see a CFHC provider sooner.

2) If you arrive to an office visit more than **10 minutes late** you may be rescheduled. Each office can determine if the patient can still be seen or not be seen depending upon appointment availability in that office on that day.

3) If you **"No Show" three times** in one year you will be placed on suspension which means you will only be eligible for walk-in appointments. After one year you can fulfill a re-education requirement by completing a verbal education with the Health Center Administrator. You will then be eligible for reinstatement for being able to make appointments.

My signature means that I have read Central Florida Health Care's **No Show & Late Arrival Agreement** and understand that it is my responsibility to call CFHC if I cannot make my appointment for any reason.

Patient Name	Date of Birth	Date

Patient Signature or Parent/Guardian if minor	Relationship to Patient

CFHC Staff Signature	Date