COMMUNITY HEALTH CENTERS OF PINELLAS, INC.

Date: _____

REGISTRATION FORM

SSN: _____-_____-_____

Name: _____ Preferred Name (if any): _____

Sex at Birth: ☐ Male ☐ Female Gender Identity: ☐ Transgender Male ☐ Transgender Female ☐ Other ☐ Decline to answer

Sexual Orientation: ☐ Straight ☐ Lesbian/Gay ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose

Date of Birth: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Race (Check all that apply):

☐ Asian ☐ Black ☐ White

☐ American Indian/Alaskan Native ☐ Native Hawaiian ☐ Pacific Islander

Ethnicity (Check one): ☐ Hispanic/Latino ☐ NOT Hispanic/Latino

Language:

☐ Albanian	☐ English	☐ Hmong	☐ Laotian	☐ Sign Language
☐ Arabic	☐ French	☐ Japanese	☐ Portuguese	☐ Tagalog
☐ Cambodian (Khmer)	☐ German	☐ Korean	☐ Russian	☐ Vietnamese
☐ Chinese	☐ Greek	☐ Kreyól	☐ Spanish	☐ Other

Employment Status: ☐ Employed ☐ Self-employed ☐ Disabled ☐ Retired ☐ Student (Part time / Full time)

Company Name: _____

Patient's Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Home Phone: _____ Cell Phone: _____

How did you hear about us? _____ Preferred Phone: ☐ Home ☐ Cell

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Annual Gross Income (before taxes): _____ Number of people supported in household: _____

**Are you homeless? ☐ Yes ☐ No If yes, choose one of the following: ☐ Shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Other

Are you currently utilizing Public Housing? ☐ Yes ☐ No

Are you a military veteran? ☐ Yes ☐ No Military Discharge? ☐ Yes ☐ No Discharge Date: _____

Are you a refugee? ☐ Yes ☐ No If yes, what is your country of origin? _____

Do you have insurance? ☐ Yes ☐ No If yes, Policy Holder Name and Date of Birth: _____

Name of Insurance Company: _____ Member ID #: _____

Emergency Contact name: _____ Phone: _____

Relationship to emergency contact: _____

Parent/Legal Guardian Information (*complete only if patient is a minor*)

Mother's Name (First & Last): _____

Father's Name (First & Last): _____

Guardian's Name (First & Last): _____

Relationship to patient: ☐ Parent ☐ Grandparent ☐ Foster Parent ☐ Other: _____

Social Security: _____ - _____ -_____ Identification: _____

Preferred Pharmacy: _____ Mother's maiden (last) name: _____

Are you a US Citizen?: ☐ Yes ☐ No Are you a Pinellas County Resident?: ☐ Yes ☐ No

**Homeless Status:

- Shelter – You are living in an organized shelter for homeless persons.
- Transitional Housing – You are residing in a small unit that helps a person transition from homelessness to permanent housing.
- Double Up – You are living with other individuals in their home and/or apartment.
- Street – You are living outdoors, in a car, in an encampment (tent city), in a makeshift housing/shelter.
- Other – You are living in a single room occupancy hotel or motel or other day-to-day paid for housing.

_____

Patient/Parent/Legal Guardian Signature

COMMUNITY HEALTH CENTERS OF PINELLAS, INC.

Patient Name: _____

Date of Birth: _____

PATIENT CONSENTS AND ACKNOWLEDGEMENTS

		INITIAL
I.	**Consent for Treatment** I hereby give consent and authorize treatment at Community Health Centers of Pinellas, Inc. for myself, the patient.	
II.	**Consent for Treatment of a Minor** I, as the parent or legal guardian of the patient, do hereby give my consent and authorize treatment. Furthermore, I grant permission for _____ to authorize Medical Treatment in my absence.	
III.	**Medical Home:** I choose to participate in the patient-centered medical home.	
IV.	**Notice of Privacy Practices** I acknowledge that I have received the practice's Notice of Privacy which describes the ways in which the practice may use and disclose my healthcare information for its treatment and payment/healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Compliance Officer if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy.	
V.	**Release of Information** • Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions or for any other purpose related to benefit payment. • If I am covered by Medicaid or Medicare, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, drug and alcohol treatment and discharge summary. • Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases such as HIV and AIDS. I hereby permit the practice and the physicians or other health professionals involved in my care to release healthcare information for purposes of treatment, payment, and/or healthcare operations.	
VI.	**Disclosure to Friends and/or Family Members** I give permission for my Protected Health Information to be disclosed for purposes of coordinating health care needs, communicating results, findings and care decisions to the friends and/or family members listed below:	

Name	Relationship	Contact Number

**You have the right to revoke whom we talk with about your health care at anytime. Please complete a new consent.

		INITIAL
VII.	**Consent for Use and Disclosure of Protected Health Information (PHI)** May we call your job and leave a message? If yes, at what number? _____ — Yes ☐ No ☐ May we call your home and leave a message? If yes, at what number? _____ — Yes ☐ No ☐ May we leave a message concerning medical information on your cell phone? If yes, at what number? _____ — Yes ☐ No ☐	
VIII.	**Consent to E-mail or Text Message for Appointment Reminders and Other Healthcare Communications.** Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at anytime I provide an email or text address at which I may be contracted, I consent to receiving appointment reminders and other healthcare communications/information at that email address or mobile number from the practice. **I consent to receive TEXT messages for: appointment reminders, feedback, and general health reminders/information at this mobile number: _____.** **I consent to receive EMAIL messages for: appointment reminders, feedback, and general health reminders/information at this email address: _____.** *Community Health Centers of Pinellas, Inc. does not charge for this service, but standard text messaging and data rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).*	
IX.	**Revocation (If you DO NOT want to receive text messages or email from us about future appointment reminders, feedback, and general health).** ☐ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via TEXT messaging. _____ _____ Signature of Patient or Parent/Guardian Date ☐ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via EMAIL. _____ _____ Signature of Patient or Parent/Guardian Date	
X.	**Patient Rights, Responsibilities and Information** and **Patient Centered Medical Home** These documents are posted in the lobby. I acknowledge that I have received a copy of each.	
XI.	**Notice of Policy Regarding Advanced Directives (for patients over 18 years of age)** Advanced Directives are legal statements that indicate the type of medical treatment wanted or not wanted in the event an individual is unable to make decisions as well as who is authorized to make them. Advance directives are made and witnessed prior to serious injury. In accordance with federal and state law, this serves as notification that we will set aside your advance directive in the event you experience a life threatening event while at one of the Community Health Centers of Pinellas locations and you will be transferred to a higher level of care. By signing below, you agree and understand this as notification. Please indicate below whether or not you have an advanced directive or if you would like to receive information on advance directives. ☐ I have an advanced directive. ☐ I do not have an advanced directive. ☐ I would like to receive information on advanced directives.	
XII.	**Residents and Students** I understand that Community Health Centers of Pinellas, Inc. supports the education of medical and legal professionals and maintains Residents and Students that may assist in relation to care.	

_____ _____

Signature of Patient or Parent/Guardian Date

COMMUNITY HEALTH CENTERS OF PINELLAS, INC.

Patient Name: _____

Date of Birth: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ – 2)

Today's Date: _____

Please answer the following questions to the best of your ability. All your answers will be kept private.

Over the last two (2) weeks, how often have you been bothered by any of the following problems? (Circle a number)

	0 days a week	1-3 days a week	4-5 days a week	6-7 days a week
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3

Add two circled numbers together.

If your total number is 3 or higher, please turn paper over and complete PHQ-9. Thank you.

Total

COMMUNITY HEALTH CENTERS OF PINELLAS, INC.

Patient Name: _____

Date of Birth: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ – 9)

Today's Date: _____

Please answer the following questions to the best of your ability. All your answers will be kept private.

Over the last two (2) weeks, how often have you been bothered by any of the following problems? (Circle a number)

	0 days a week	1-3 days a week	4-5 days a week	6-7 days a week
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed, OR the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3

add columns _____ + _____ + _____

(Healthcare professional: For interpretation of total, please refer to scoring card below)

Total _____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not Difficult at All	Somewhat Difficult	Very Difficult	Extremely Difficult

NEW PATIENT HEALTH RISK ASSESSMENT

COMMUNITY HEALTH CENTERS OF PINELLAS, INC.

Patient Name: _____

Date of Birth: _____

Today's Date: _____

1. Who was your previous provider(s) / physician(s)? _____
2. When did you last see your previous provider(s) / physician(s)? _____
3. Are you taking any prescribed, over the counter, or herbal medicines? ☐ Yes ☐ No If yes, please list below:

Medicine/Vitamin/Supplement Name	Dose-How much you take	How often do you take it?	Refill needed?

4. Are you allergic to any medications, foods, etc.? ☐ Yes ☐ No If yes, explain: _____
5. Do you use tobacco? ☐ Yes ☐ No If yes, ☐ Smokeless Tobacco (chew) ☐ Cigarettes, # per day: _____; ☐ I want to quit
6. Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____ ☐ Alcohol Use in the Past
7. What languages do you speak? _____ What languages do you read? _____
8. What is your highest level of education? ☐ Grades 1-6 ☐ Grades 7-12 ☐ College ☐ No Formal Education
9. How do you prefer to learn? ☐ Person to Person ☐ Hand-outs ☐ Video/audio tapes
10. Do you have any special educational needs we should be aware of in the following areas?
    ☐ Hearing ☐ Sight ☐ Speech ☐ Spiritual ☐ Cultural Beliefs ☐ None
11. At this time, do you have any limitations or emotional barriers that may affect your ability to learn? ☐ Yes ☐ No
12. When you are given instructions from your doctor or pharmacist, how often do you need someone to help you?
    ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always
13. Do you have difficulty doing any of the following things for yourself? ☐ Bathing ☐ Dressing ☐ Shopping ☐ Eating

PAST SURGICAL HISTORY

14. Have you ever had surgery? If Yes, Where, When and Why?

_____

☐ Hysterectomy: ☐ Total ☐ Partial _____

☐ Mastectomy: ☐ Right ☐ Left ☐ Bilateral _____

☐ Tubal Ligation _____

☐ Vasectomy _____

☐ Colectomy _____

☐ Cholecystectomy _____

☐ Other Prior Surgery/Procedural _____

_____

PATIENT HISTORY:

15. Have you ever been a victim of abuse or neglect? ☐ Yes ☐ No
15. Have you had any falls, trauma or other injury? ☐ Yes ☐ No
16. What is your usual diet? ☐ Regular ☐ Low Salt ☐ Akins Diet ☐ Low Cholesterol ☐ Vegetarian ☐ Other: _____
17. Have you lost significant weight recently? ☐ Yes ☐ No If yes, how much? _____
18. Are you currently employed? ☐ Yes ☐ No
19. Your occupation _____
20. Do you live alone? ☐ Yes ☐ No
21. Do your daily activities require that you stay in the sun often? ☐ Yes ☐ No
22. Have you ever been exposed to asbestos, radiation, chemicals or fumes? ☐ Yes ☐ No
23. Do you have an Advanced Directive or Living Will? ☐ Yes ☐ No

NEW PATIENT HEALTH RISK ASSESSMENT

SAFETY:

24. Do you wear your seatbelt? ☐ Yes ☐ No 25. Do you have a smoke detector? ☐ Yes ☐ No

26. Are you sexually active? ☐ Yes ☐ No If yes, do you use condoms? ☐ Yes ☐ No ☐ Other protection: _____

MEDICAL / FAMILY HISTORY:

28. Mother ☐ Living ☐ Deceased, cause of death: _____

29. Father ☐ Living ☐ Deceased, cause of death: _____

30. Siblings # Living _____ # Deceased _____ If Deceased, cause: _____

31. Have you or any of your blood relatives (parents, siblings, grandparents) had any of the following?

Self		Mother	Father	Siblings	Grandparents
☐	Arthritis	☐	☐	☐	☐
☐	Asthma	☐	☐	☐	☐
☐	Bleeding/Clotting Disorders	☐	☐	☐	☐
☐	Cancer	☐	☐	☐	☐
☐	COPD / Emphysema	☐	☐	☐	☐
☐	Depression, Anxiety, Psych Disorders	☐	☐	☐	☐
☐	Diabetes	☐	☐	☐	☐
☐	Early Death (before age 50)	☐	☐	☐	☐
☐	Environmental Allergies	☐	☐	☐	☐
☐	Genetic Disease	☐	☐	☐	☐
☐	Headache / Migraines	☐	☐	☐	☐
☐	Heart Disease	☐	☐	☐	☐
☐	Hepatitis	☐	☐	☐	☐
☐	High Cholesterol	☐	☐	☐	☐
☐ Year of Diagnosis: _____	HIV / AIDS	☐	☐	☐	☐
☐	Hypertension/High Blood Pressure	☐	☐	☐	☐
☐	Kidney / Bladder Disease	☐	☐	☐	☐
☐	Osteoporosis	☐	☐	☐	☐
☐	Seizure disorder / Epilepsy	☐	☐	☐	☐
☐	Sickle Cell Anemia	☐	☐	☐	☐
☐	Stroke	☐	☐	☐	☐
☐	Thyroid disorder	☐	☐	☐	☐
☐	Tuberculosis	☐	☐	☐	☐

OVER 50 YEARS ONLY

Date of Last Colonoscopy: _____

FOR WOMEN ONLY:

Date of last Pap Smear: _____ Where? _____

Date of Last Mammogram: _____ Where? _____

32. Date Last Period _____ 33. Any menstrual problems or recent changes? ☐ Yes ☐ No

34. How many times have you been pregnant? _____ 35. How many full-term pregnancies have you had? _____

36. How many premature pregnancies have you had? _____ 37. How many abortions have you had? _____

38. How many miscarriages have you had? _____ 39. How many ectopic pregnancies have you had? _____

40. How many of your children are living? _____

COMMUNITY HEALTH CENTERS OF PINELLAS, INC.

PRIVACY NOTICE

The U.S. Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of protected health information (PHI) about the patient, in order to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum information to only those we feel are in need of your health care information, treatment, payment and/or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and we may have to disclose PHI for the purposes of treatment, payment, or other health care operations. Theses entities are most often not required to obtain patient/guardian consent.

You may refuse to consent to the use or disclosure of your PHI, but this must be in writing. Under the law, we have the right to refuse to treat you, should you refuse to disclose your PHI. If you choose to give consent in this document, at some future time, you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the **Right to:**

- Inspect and obtain a copy of your health information, which includes billing information.
- Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility. Any request for amendment must be sent in writing to the Center Director/Compliance Officer or designee.

  We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.
- An Accounting of Disclosures: You have the right to request and accounting of disclosures. This is a list of certain disclosures we made of your health information for purposes other than treatment, payment or health care operations where an authorization was not required.
- Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. Any request for a restriction must be sent in writing to the Center Director/Compliance Officer or designee.

  We are required to agree to your request only if 1) except as otherwise required by law the disclosure to your health plan and the purpose is related to payment or health care operations (and not treatment purposes) and 2) your information pertains to health care services for which you have paid in full. **For other requests we are not required to agree.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
- Request Confidential Communication: you have the right to request that we communicate with you about medical matters in a certain way or at a certain location. CHCP will grant reasonable requests for confidential communications at alternative locations and or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by CHCP and related correspondence regarding payment for services. Please realize we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response.
- Complaints: if you believe your privacy rights have been violated you may file a written complaint with the Center Director/Compliance Officer or designee. You may also file a complaint with the Secretary of US Department of Health and Human Services.

CHCP may disclose your PHI:

- To business associates we have contracted with to perform agreed upon service and billing for it;
- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health-related benefits or services;
- To inform Funeral Directors consistent with applicable law;
- For population based activities relating to improving health or reducing health care costs; and
- For conducting training programs or reviewing competence of health care professionals.

When disclosing information, primarily appointment reminders and billing efforts, we may leave messages on your answering machine/voice mail.

Future Communications: We may communicate to you via newsletters, mail outs or other means regarding services, health reminders, disease management programs, wellness programs or other community based initiatives or activities involving CHCP.

CHCP and its medical staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment and health care operations. Physicians and caregivers may have access to PHI in their offices to assist in reviewing past treatment as it may affect treatment at this time.

As required by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Military Command Authorities
- Health Oversight Agencies
- Funeral directors, Coroners and Medical Directors
- National Security and Intelligence Agencies

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice.

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of PHI has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI-in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes, in any way, to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation properly and promptly.

Thank you for being one of our very highly valued patients!

COMMUNITY HEALTH CENTERS OF PINELLAS, INC.

Date: _____

Dear Patient,

As a way to save you money on your healthcare, Community Health Centers of Pinellas, Inc. (CHCP) offers discounts based on your entire household's income. To qualify for a discount, CHCP accepts any of the following documents:

- Payroll – Current pay stubs for one month
- Child Support – Court Order
- Alimony – Court Order
- AFDC – Notice of case action from HRS
- SSI – Letter from Social Security Office
- Pensions – Letter stating allotment
- Disability – Letter from Social Security Office
- Unemployment Compensation – Wage transcript from State
- Worker's Compensation – Wage transcript from State
- Self Declaration/Allowance – Letter from source for proof
- Tax returns with W2's – a complete copy including all signatures of person filing and person/organization preparing the return
- Other documents as means of support and annual income (i.e. letter from employer on company letterhead).

Without this information, we will not be able to qualify you for discounted services.

Thank you,

Community Health Centers of Pinellas

COMMUNITY HEALTH CENTERS OF PINELLAS, INC.

PATIENT RIGHTS, RESPONSIBILITIES AND INFORMATION

MEDICAL HOME

1. In a patient's Medical Home, an interdisciplinary team guides care in an accessible, comprehensive and continuous manner.
2. The Medical Home:
    - Takes responsibility for coordinating the patient's healthcare.
    - Knows its patients and is oriented to the whole person with unique needs.
3. In a Medical Home:
    - Patients and clinicians are partners in making treatment decisions and must have open communication.
    - The patient has ready access to care.
4. A Medical Home fosters and environment of trust and respect. The patient-centered Medical Home provides care that is safe, timely, effective, equitable, and family-focused.

PATIENT RIGHTS

A patient has the right to:

1. Be treated with courtesy and respect, with appreciation of his/her individual dignity, and with protection of his/her need for privacy.
2. A prompt and reasonable response to questions and requests.
3. Know who is providing medical services and who is responsible for his/her care.
4. Know what support services are available, including whether an interpreter is available if s/he does not speak English.
5. Know what rules and regulations apply to his/her conduct.
6. Refuse any treatment, except as otherwise provided by law.
7. Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
8. Treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
9. Change providers if other qualified providers are available.
10. Express grievances regarding any violation of rights, as stated in Florida law, though the grievance procedure of the health care provider or facility and to the appropriate state licensing agency.

INFORMATION

A patient has the right to:

1. Request information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
2. Be given, upon request, information and counseling on the availability of financial resources for care.

3. Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
4. A copy of an itemized bill and, upon request, to have the charges explained.
5. Know if medical treatment is for purposes of experimental research and to consent or refuse to participate in each experimental research.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the Medical Home team/health care facility accepts to Medicare assignment rate.

PATIENT RESPONSIBILITIES

A patient is responsible for:

1. Providing to the health care provider accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other health related matters.
2. Notifying the Medical Home team of any changes in their health status.
3. Knowing and identifying who are his/her Medical Home team members.
4. Reporting to the Medical Home team whether they comprehend the treatment plan and understand what is expected of him/her.
5. Following the treatment plan recommended by the Medical Home team.
6. His/her action if one refuses treatment or does not follow the health care provider's instructions.
7. Information the Medical Home team about a living will, medical power of attorney, or advance directive that could affect his/her health care.
8. Assuring that the financial obligations to the medical home are met as promptly as possible.
9. Following the Medical Home's rules and regulations affecting patient care and conduct.
10. Keeping appointments and, when unable to do so, notifying the Medical Home to reschedule.

You may openly communicate your dissatisfaction and raise questions or concerns about the service you have received without fear. CHCP wants to know about your dissatisfaction or concerns and encourages you to contact us or tell one of our staff. They can assist you in resolving difficulties and address your concerns. If an individual staff member is unable to help you, they will involve the healthcare provider or the Office Manager in an attempt to resolve the issue. If you feel your concerns have not been addressed, you may contact:

The Director of Clinical and Quality Operations at 727-824-8130

If you remain dissatisfied and want to file a formal complaint, you may do so by calling:

Customer Service at 1-888-419-3456 or write to the address below:
Agency for Health Care Administration
Consumer Services Unit
PO Box 14000
Tallahassee, FL 32317-4000