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

---

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

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)

	Yes	No
May we call your job and leave a message? If yes, at what number? ________________________________		
May we call your home and leave a message? If yes, at what number? ________________________________		
May we leave a message concerning medical information on your cell phone? If yes, at what number? ________________________________		

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: ______________________
Today's Date: ______________________

MEDICAL HISTORY FORM FOR DENTAL PATIENTS

Please answer the following questions:

If you are completing this for another person, what is your name and relationship? ______________________

Date of last physical exam: ______________________ Referred by: ______________________

Name of Primary/Specialty Physician: ______________________ Phone: ______________________

Address of Physician: ______________________

Patient's Sex: ☐ Male ☐ Female Patient's Height: ______________ Patient's Weight: ______________

	Yes	No
Are you in good health?	☐	☐
Have there been changes to your health in last year?	☐	☐
Do you take steroids/corticosteroids?	☐	☐
Are you taking blood thinners?	☐	☐
Have you ever had chemotherapy or radiation?	☐	☐
If yes, was it to your head/neck?	☐	☐
Have you **ever** taken any medications for osteoporosis either via IV or pill form?	☐	☐
If yes, what medication and for how long? ______________________		
For Children: Has the child ever been sedated (put to sleep) for dental treatment?	☐	☐

	Yes	No
Are you wearing contact lenses?	☐	☐
Are you wearing removable dental appliances?	☐	☐
Do you smoke/chew tobacco?	☐	☐
If yes, how many packs/cans per day? __________		
Do you have any metal implants in your body?	☐	☐
If yes, where? ______________________		
Have you ever had a broken jaw?	☐	☐
Have you ever had braces?	☐	☐
Have you had any complications with dental treatment?	☐	☐
If yes, what?______________________		
Are you a patient in CHCP?(OB, Pediatrics, Family Practice)	☐	☐

Medical History: Do you have any of the following? ☐ No ☐ Yes, please check all that apply

☐ Damaged/Artificial Heart Valves	☐ Autoimmune Disease	☐ Kidney Disease/Dialysis	☐ Low Blood Pressure/Fainting
☐ Cardiovascular Disease	☐ Thyroid Disease	☐ Tuberculosis	☐ STDs
☐ Diarrhea or recent weight loss	☐ Respiratory Problems	☐ Persistent Cough	☐ Epilepsy/Seizures
☐ Diabetes	☐ Arthritis	☐ Coughing up Blood	☐ Mental Health Problems
☐ Liver Disease/Hepatitis	☐ Ulcers/Acid Reflux	☐ Swollen glands in neck	☐ Anemia/Sickle Cell
☐ Osteoporosis/Osteopenia	☐ Cancer	☐ Abnormal Bleeding	☐ AIDS/HIV, date of diagnosis:
☐ Asthma/COPD	☐ Blood Clotting Disorder	☐ High Blood Pressure	______________

If you checked Cancer, what kind? ______________________ When?______________________

Allergies: Do **YOU** have any allergies? ☐ No ☐ Yes, please indicate items you are allergic to

☐ Drug/Medication Allergies: ______________________
☐ Food/Environmental: ______________________

☐ Local anesthetics ☐ Sulfa drugs ☐ Aspirin
☐ Penicillin or other antibiotics ☐ Iodine ☐ Barbiturates, sedatives, or sleeping pills

Hospitalizations/Surgeries:

Have you ever had any serious illness, operations, or been hospitalized in the past 5 years? ☐ No ☐ Yes, please fill out below

☐ Serious Illnesses/Operations: ______________________

☐ Hospitalizations:______________________

WOMEN ONLY:

	Yes	No
Are you pregnant?	☐	☐
Do you have any problems associated with your period?	☐	☐

	Yes	No
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

*Taking antibiotics may cancel out the effects of birth control, and you may get pregnant.

PLEASE TURN PAGE OVER →

Current Medicines: Include any prescription or over-the-counter medications (vitamins, antihistamines, Tylenol, herbs, etc.)

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

Chief Dental Complaint: ____

____

____

☐ I certify that I have read and understand the above. I acknowledge that my questions, if any, about this medical history form, have been answered to my satisfaction and I will not hold my dentist, or any member of the staff, responsible for any errors or omissions that I have made in the completion of this form.

☐ I understand that in the event there is any change in my health status, I should notify CHCP at the earliest possible time.

☐ I hereby consent to the administration of local anesthesia as may be considered necessary by the dentist in charge of my care. I understand the risks of local anesthesia include: local discomfort, swelling, bruising, sores, allergic reactions, seizures, and temporary and/or permanent numbing. I have also read the attached sheet of the benefits, risks, and complications of local anesthesia.

______________________________ ______________

Signature of Patient/Legal Guardian Date

For completion by the Dentist:

☐ Medical Consult Required: ____

☐ Pre-Medication Required: ____

______________________________ ______________

Signature of Dentist Date

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!

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