CARE 4 U
COMMUNITY HEALTH CENTER
"Because We Care!"

4690 NW 7th Avenue
Miami, Florida 33127
Phone: (305) 835-0101
Fax: (305) 835-0102

PATIENT INTAKE FORM

Initial Date: ________________ Today's Date: _______________ Patient Number: ______________

DEMOGRAPHIC DATA

Patient Name: ____ S.S #: ____________________

What is your mother's maiden name? ______________________

Date of Birth: ___________________ Sex: ☐ Male ☐ Female ☐ Transgender (M to F or F to M)

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partnered

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic

Race: ☐ White ☐ African American ☐ American Indian or Native Indian
☐ Asian ☐ Pacific Islander

What is your preferred language? _______________________

Address: ____

City: __________________ State: _________ Zip Code: _________________

Telephone Number: ___________________________ Other Phone: ___________________________

Employment Status: ___________________________ Disabled? ☐ Yes ☐ No

Employer: ____

Address: ____

City: __________________ State: _________ Zip Code: _________________

Employer Contact Number: _________________________ Annual income: _______________________

Would you be interested in having communications sent to you via your e-mail address?
(Example: appointment reminders, administrative updates and health bulletins) ☐ Yes ☐ No

If yes, please give email address: ____

How did you hear about our practice? ____

EMERGENCY CONTACT

Name: ____________________________________ Relationship: _____________________

Address: ____

City: __________________ State: _________ Zip Code: _________________

Telephone Number: ___________________________ Other Phone: ___________________________

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INSURANCE INFORMATION

Primary Insurance: ☐ Yes ☐ No

Plan Name: ______________________________

I.D. Number: ______________________________

Group Number: ______________________________

Effective Date: ______________________________

Policy Holder Name: ______________________________

D.O.B: ____________________ S.S #: ____________________

Secondary Insurance: ☐ Yes ☐ No

Plan Name: ______________________________

I.D. Number: ______________________________

Group Number: ______________________________

Effective Date: ______________________________

Policy Holder Name: ______________________________

D.O.B: ____________________ S.S #: ____________________

Self-Pay: ☐ Yes ☐ No

GUARANTOR

Person responsible for the bill (Complete only if different from patient) ☐ NA

Guarantor Name: ____________________ S.S #: ____________________

Relationship to Patient: ☐ Spouse ☐ Parent Date of Birth: ____________________

Address: ______________________________

City: ______________ State: __________ Zip Code: ______________

Telephone Number: ____________________ Other Phone: ____________________

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Care4UCHC. I acknowledge that I am financially responsible for the payment whether or not covered by insurance.

Signature: ____________________ Date: ______________

WORKER COMPENSATION

Is your visit due to job related injury or automobile accident? ☐ Yes ☐ No *If yes, please notify the front desk staff*

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OFFICE POLICIES

My signature below indicates that I have been provided with a copy and an opportunity to ask question about the practices' privacy practices (HIPPA), Patient's Right & Responsibilities, Grievance Policy & Procedures, Living Will & Advance Directives, and the Sliding Fee Discount Program Application.

_______________________________________ ______________________

Parent or Legal Guardian Signature Date

****

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of following documents provided to the patient and the Patient Refused to Sign.

☐ HIPPA & Privacy Practices
☐ Patient's Right & Responsibilities
☐ Grievance Policy & Procedures
☐ Living Will & Advance Directives
☐ Sliding Scale Fee.
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgment
☐ Other

_______________________________________ ______________________

Employee Signature Date

****

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PATIENT INTAKE

Informed Consent for Receiving Treatment

(If, the patient being treated is under 18 years of age Parent or Legal Guardian's Consent is required for treatment)

I, ______________________________, do hereby state that I am the ☐ Patient OR ☐ (Parent or legal Guardian of minor child) of the aforementioned child and do hereby voluntarily consent to the rendering of medical care, including diagnostic procedures and medical treatment, by authorized members of the Care 4 U Health Community Health Center (C4UCHC) clinical staff or their designees, as may be in their professional judgment necessary. I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on me.

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to C4UCHC. I acknowledge that I am financially responsible for the payment whether or not covered by insurance.

I have read this form and certify by signing below that I understand informed consent for treatment, risk and benefits, and was given an opportunity to ask questions and my question were answered satisfactorily contents and have been given explanation of the benefit and risks of treatment.

______________________________ ______________________
Patient's Signature Date

______________________________ ______________________
Parent or Legal Guardian's Signature Date

______________________________ ______________________
Witness's Signature Date

****

Consent for to Share PHI with Designated Individuals (HIPPA)

I give consent to C4UCHC. C4UCHC has the authority to discuss my health information with the following individuals:

Name	Relationship	Phone Number	May we leave a voice message?
1.	Parent/Legal Guardian		
2.			
3.			

______________________________ ______________________________
Parent or Legal Guardian's Signature Witness's Signature

****

(If, the patient being treated is under 18 years of age Parent or Legal Guardian's Consent is required for treatment)

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Temporary Consent for Treatment of Minor Accompanied by Designated Adult

This form grants temporary authority to a designated adult to provide and arrange for medical care for a minor in the event of an emergency where the minor is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them. This form should be given to the Coach or adult who presents with the child.

Minor Full Legal Name: ____________________ Date of Birth: _________ Gender: ☐ Female ☐ Male

Address: ____

City: __________________ State: _________ Zip Code: _________________

Information for Medical Treatment Physician's Name and Location of Practice

Care 4 U Community Health Center | 4690 NW 7th Avenue, Miami Florida 33127 | Phone: 305-835-0101
Medical Insurer/Health

Insurance Information

Plan: _______________________________ Policy #: _______________________________

Allergies to Medications: ________________________ Allergies (Other): ________________________

Note all conditions for which the child is currently receiving treatment: ____________________________

Note any other significant medical information: ____

The legal Guardian or Parent must sign this form granting Temporary Authority for Consent for Treatment of the Minor.

Authorization and Consent of Parent(s) or Legal Guardian(s)

I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for ____ (hereafter "**Designated Adult**") to administer general treatment for any minor injuries or illnesses experienced by the Minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Designated Adult to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Designated Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective through: _______________. Signed this ______day of________, 20_____.

Parent/Legal Guardian Signature: _____________________ Printed Name: ____________________

Witness Signature: _________________________________ Printed Name: ____________________

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PATIENT INTAKE

DESIGANTION OF HEALTH CARE SURROGATE

Name: ____

In the event I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate, as my surrogate for health care decisions:

Name: ____

Address: ____

City: ________________ State: ________ Zip Code: ________________

Telephone Number: _________________________

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name: ____

Address: ____

City: ________________ State: ________ Zip Code: ________________

Telephone Number: _________________________

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

Additional Instructions (optional): ____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name: ____

Name: ____

Signed: ____

Witnesses ____

____

At least one witness must not be a husband or wife or a blood relative of the principal.
— This form offered as a courtesy of The Florida Bar and the Florida Medical Association —

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LIVING WILL

Declaration made this _________ day of _________ 2 _____, I ____________________________willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated and

_________ (initial) I have a terminal condition, or
_________ (initial) I have an end stage condition or
_________ (initial) I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name: ____

Address: ____

City: ___________________ State: _________ Zip Code: _________________

Telephone Number: ___________________

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional):

(Signed): ____

Witness: ____

Address: ____

City: ___________________ State: _________ Zip Code: _________________

Telephone Number: ___________________

Witness: ____

Address: ____

City: ___________________ State: _________ Zip Code: _________________

Telephone Number: ___________________

The principal's failure to designate a surrogate shall not invalidate the living will.
— This form offered as a courtesy of The Florida Bar and the Florida Medical Association —
Suggested form of a Health Care Surrogate, Florida Statutes Section 765.203

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SLIDING FEE DISCOUNT PROGRAM APPLICATION

It is the policy of Care 4 U Community Health Center (C4UCHC) to serve individuals and family regardless of inability to pay. Ability to pay is based on family income and family size. C4UCHC Sliding Fee Discount Program applies to individuals and families with gross annual incomes at or below 200 % of the Federal Poverty Level. You may receive services provided by C4UCHC at a nominal fixed charge if your annual family income falls at or below 100 % of the Federal Poverty Level. A discount will be given to a family with Family Income greater than 100% and less than or equal to 200 % of the FPL.

If you wish to receive this benefit please complete the application below, provide proof of income and attest with your signature that to the best of your knowledge the information you have provided is true and accurate.

Family Size and Income Information				
Family Member Name	**Date of Birth**	**Relationship to Patient**	**Income Amount**	**Proof of Income (Staff Only)**
1. Patient:		**SELF**		
2.				
3.				
4.				
5.				
6.				
7.				
Total				

Attestation

Patient Signature ______________________ Date ______________

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PATIENT RESPONSIBILITIES

As a client of Care 4 U Community Health Center (C4UCHC), you have many responsibilities too. We always want to make sure you understand your responsibilities and accept the credit for your success in treatment. We expect you:

- To maintain the confidentiality of other clients.
- To follow the Program Rules.
- To follow the grievance procedure as outlined in the Client Grievance.
- Procedure for any problem or concern.
- To inform therapist/case managers at the agencies from which you receive services, that you are also receiving services from C4UCHC coordination of services between agencies is to your benefit.
- To treat all C4UCHC staff, volunteers, and clients respectfully; you will not be verbally or physically abusive.
- To follow the treatment plan that you have developed with your physician, therapist and/or case manager.
- To keep all scheduled appointments (medical, lab, dental, case management, individual and group therapy). You will give 24 hour notice if you need to miss an appointment and reschedule the appointment with your physician, therapist and/or case manager.
- To attempt to remain drug and alcohol free while on the premises of C4UCHC.
- To provide C4UCHC staff with an update of any changes in your status (physical, financial, emotional).
- To provide your own transportation whenever possible. If unable to provide your own transportation; you should contact your case manager.
- To allow your providers to consult with other health care professionals about your care.
- To arrange for payment of medical bills and applying for all benefits and entitlement programs for which you are eligible.
- Making sure that any and all bills relating to your health care are paid on time.

____________________________________ _______________________
Print Name Date

____
Signature

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. YOU DO NOT NEED TO RESPOND TO THIS NOTICE.

Care 4 U Community Health Center Responsibilities

Care 4 U Community Health Center is required by law to maintain the privacy of your protected health information in our custody. We must provide you with notice of our legal duties and privacy practices with respect to your health information. We must also follow the terms of this notice.

How Care 4 U Community Health Center Uses and Safeguards your Health Information

If you are a Medicaid/MediKids recipient, we use your health information to pay for your health services and to operate the Medicaid program. We may also use your health information to tell you about treatment alternatives or other health-related benefits and services.

The following are some examples or how we may use your health information:

- Your doctor may send us a claim to pay. The claim includes information that identifies you and the type of care you received.
- We may share your information with a company that reviews hospital records to check on the quality of care that you received.
- We may send appointment reminders for Child Health Check-Up services.

Care 4 U Community Health Center may also use and disclose your health information as permitted by law, such as:

- To entities outside the agency for purposes directly connected with the administration of the State Medicaid plan.
- In responding to public emergencies, access to your health information may be granted to persons or agency representatives who are subject to standards of confidentiality comparable to those of Care 4 U Community Health Center. Such other agencies may include the Federal Emergency Management Agency (FEMA) or the Centers for Disease Control (CDC).
- Where disclosure would assist in determining eligibility for benefits, amount of medical assistance payment or otherwise assists the agency in the administration of the Medicaid program.
- To the confidential Florida abuse hotline in order to report abuse, neglect and/or domestic violence as per criteria and conditions imposed on the agency by law.
- For health oversight activities and/or administration of the Medicaid program, such as inspections, investigations, and audits.
- To conduct research to benefit the Medicaid program.
- For purposes of treatment, payment, or our operations and as otherwise required by law.

Other uses or disclosures of your protected health information require your or your personal representative's written authorization. For example, we will not use or disclose psychotherapy notes without your written authorization or as allowed by law. We will not use or disclose your protected health information for marketing purposes without your written authorization and we will not sell your protected health information without your written authorization. We also are prohibited by law from using or disclosing genetic information for insurance underwriting purposes. At any time, you may revoke authorizations in writing. If you cannot give your authorization due to an emergency, we may release your health information if it is in your best interest.

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Your Health Information Rights

You have the following rights with respect to your protected health information:

To see or obtain a copy of your health information that is maintained by Care 4 U Community Health Center. We may not be able to provide health information that includes psychotherapy notes, is part of a legal case, or is otherwise excluded from disclosure by law. We may charge a copying fee.

- To request that we amend health information we maintain that you believe is incorrect or incomplete.
- To request a list of disclosures we have made of your health information. The list may not include disclosures authorized by you, disclosures for treatment, payment and health care operations, or other disclosures permitted by law.
- To request that we contact you at a different address or phone number, if contacting you about your health information at your present location would endanger you.
- To request that we limit the use and disclosure of your health information. We are not required to agree to your request.
- To request another paper copy of this notice.
- To opt-out of fundraising communications from us should the agency ever engage in fundraising.
- To receive a notification from us following a breach of your unsecured protected health information.

Contact Information

If you have any questions, wish to make a request regarding your health information, or would like another paper copy of this notice, please contact the AHCA Medicaid office in your area at the telephone number listed below. We may ask you to make the request in writing.

Florida Medicaid Recipient Help Line: (877) 254-1055

Filing a HIPAA Complaint

If you believe your privacy rights have been violated by Care 4 U Community Health Center or one of its employees, you may file a complaint with AHCA and/or the Secretary of the Department of Health and Human Services at the addresses below. You will not be retaliated against for filing a complaint.

Privacy Officer
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 4
Tallahassee, Florida 32308
(850) 412-3960

Secretary
Department of Health and Human Services
200 Independence Ave. SW
Washington, D.C. 20201
(800) 368-1019

Future Changes to the Notice of Privacy Practices

Care 4 U Community Health Center reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information that we maintain. If we make a material revision to this notice, we will send a revised copy of the notice to recipient households within sixty (60) days of the revision.

Who receives the Notice of Privacy Practices

Care 4 U Community Health Center provides this notice to every patient of the health center as required by law.

I ________________________, received a copy the Notice of Privacy Practice's on _____/_____/_____.