

PHARMACY INFORMATION			
Name			
Phone Number		Address	

RACE, ETHNICITY, LANGUAGE INFORMATION			
Language		Translator ?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Race	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Bi-racial <input type="checkbox"/> Other Race <input type="checkbox"/> unreported/refuse to answer	Ethnicity	<input type="checkbox"/> No, not Hispanic/Latino <input type="checkbox"/> Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race.)

RESPONSIBLE PARTY (If other than self)			
Last Name		First Name	
Middle Name		Date of Birth	
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship	

EMERGENCY CONTACT			
Last Name		First Name	
Middle Name		Date of Birth	
Phone Number		Relationship	
Address			

PATIENT NAME			
DATE OF BIRTH		TODAY'S DATE	



PAYMENT OF BENEFITS

I authorize payments as determined by CLSC, directly to CLSC. I understand that I may still be responsible for any amounts not paid by my insurance company. For further details, I will consult the Financial Policy.

MEDICAL RELEASE AUTHORIZATION

I authorize CLSC to release any pertinent medical information necessary for my treatment, including to other physicians involved in my care and to insurance companies responsible for payment. I also authorize any insurance company, healthcare provider, employer, hospital, physician, dentist, or pharmacist to release information as needed to process my claims. I authorize direct payment of medical and surgical benefits to CLSC for services rendered. I certify that the information I provide is true and correct. I know and understand that it is a crime to fill out this form with facts that I know are false and/or to leave out facts that I know are important.

PRESCRIPTION MEDICATION HISTORY CONSENT

CLSC uses an electronic medical record system that includes electronic prescribing (ePrescribe). This system allows your provider to securely send prescriptions to your preferred pharmacy through a secure electronic connection (RxHub), helping ensure the accurate and timely delivery of your medications. To support safe and effective treatment and coordinate care with other providers, we request your consent to access your prescription medication history from pharmacies, pharmacy benefit managers (PBMs), and other healthcare providers.

By signing below, I give CLSC permission to request, access, and use my prescription medication history for treatment purposes, and to enroll me in the ePrescribe program. I understand this information will be used solely to support my care. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction.

PATIENT PORTAL & MESSAGING HEALOW CONSENT FORM

CLSC uses a secure electronic medical record system and patient portal called Healow. Through this system, CLSC may contact you by text message, email, or phone regarding your care, including appointment reminders, telemedicine visits, billing, and other healthcare-related matters. These communications may include the use of automated technology such as pre-recorded messages or auto-dialing systems. Standard message and data rates may apply. By signing below, you consent to register for and use the Healow portal to access your health information, receive updates, and communicate with your care team. While CLSC takes appropriate measures to protect your privacy, you understand that text and email communication may not be fully secure. You may opt out of any or all electronic communications at any time by informing the front desk or submitting a written request.

PATIENT NAME		TODAY'S DATE	
PATIENT SIGNATURE			



NOTICE OF PRIVACY PRACTICES

I have been informed of Complete Local Specialty Care’s (“CLSC”) health information privacy policies, as outlined below, and understand that a full copy of CLSC’s **NOTICE OF PRIVACY PRACTICE** is posted in the office. A copy of this notice will be provided to me upon my request. Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rule, outlined below. A federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our Notice of Privacy. Our practice strives to comply with HIPPA’s regulations.

WHAT IS HIPAA AND HOW DOES THE PRIVACY RULE AFFECT ME?

The Health Insurance Portability and Accountability Act (HIPAA), passed in 1996, sets national standards for protecting your personal health information. The HIPAA Privacy Rule, effective April 14, 2003, gives you rights over your medical records and limits how your information can be used and shared.

As our patient, we want you to know that we value and respect the privacy of your medical information. We are committed to doing everything we can to protect it. When it is appropriate and necessary, we may use or disclose the minimum amount of health information required for treatment, payment, or healthcare operations, and only when it is in your best interest.

We also support your full access to your medical records. At times, we may need to disclose your health information to entities involved in your care, such as laboratories or specialists, even if they do not interact directly with you. These disclosures may occur without your direct consent, as permitted by law.

You have the right to refuse consent for the use or disclosure of your personal health information, but this refusal must be submitted in writing. Please understand that under HIPAA, we have the right to decline treatment if you choose not to allow us access to necessary health information. If you choose to provide consent and later decide to revoke it, that revocation must also be in writing, and it will not apply to any actions already taken based on your original consent.

WHAT IS INDIVIDUALLY HEALTH INFORMATION (IIHI)? Any health information you provide our practice, including your mailing address. Information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payments, and/or identifies you as an individual.

WHAT IS THE NOTICE OF PRIVACY PRACTICE? Our practice has the official **NOTICE OF PRIVACY PRACTICE** posted in our office informing our patients about their rights surrounding the protection of your IIHI and our obligations concerning the use and disclosure of your IIHI. If you have any questions regarding this notice and our health information privacy practices, please contact the office manager(s).

I have read the short notice provided by CLSC’s practice and have been informed of how to obtain more information regarding our Notice of Privacy. I acknowledge that I have been informed of CLSCs Notice of Privacy Practices. I understand that a copy of the full notice is posted and is available to me upon request. I have received a brief summary of how my health information may be used and disclosed under HIPAA, and I understand my rights regarding this information.

PATIENT NAME		DATE OF BIRTH	
PATIENT SIGNATURE		TODAY’S DATE	



CONSENT TO TREAT

INFORMED CONSENT: I voluntarily consent to receive medical care and treatment from the providers at Complete Local Specialty Care (CLSC), including physicians, nurse practitioners, physician assistants, and other healthcare professionals under their supervision. I understand that this consent includes all necessary and appropriate medical services as deemed reasonable by my provider.

I will provide all necessary information related to my healthcare needs that may affect the treatment I may receive, including but not limited to; past and current medical history, past and current medications, and current medical issues. I understand that if I do not provide all necessary information pertaining to my current health, that I will not hold the providers or other employees of CLSC liable for any adverse reactions.

With my consent, CLSC, may use and disclose Protected Health Information (PHI), about me to carry out treatment, payment and healthcare operations. Please refer to the CLSC Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, CLSC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment or healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and diagnostic results.

With my consent, CLSC may contact me via Email / SMS for patient satisfaction/experience purposes.

NOTICE OF DISCLAIMER: This shall serve as notice that not all medical services are available or performed at CLSC Clinics. Services that are deemed necessary for the treatment or diagnosis of the patient and determined by our Providers as necessary or in the best interest of the management of the patient’s condition and any services that may be required at other specialized facilities outside of any CLSC Clinic locations are not part of or billed from CLSC.

Any emergency care that the attending physician or mid-level provider believes should, in the best interest of the patient, be provided by another Facility, will not be the financial responsibility of CLSC. A referral to another specialty service or facility will be done in the best interest of the patient and CLSC. CLSC has no financial interest in referral facilities or specialist referrals.

Patients must agree to see a specialist physician when a medical problem is outside the scope of general medical care or for pre-existing conditions requiring a specialist as determined by our providers.

My signature below indicates that I have read and understand the above informed consent and disclaimer, and I am consenting to treatment at CLSC.

PATIENT NAME		DATE OF BIRTH	
PATIENT SIGNATURE		TODAY'S DATE	



MEDICAL RECORD AUTHORIZATION

Fax: (954) 354 - 8151

Patient Name	
Date of Birth	
Phone Number	

I hereby authorize CLSC to: _____ Obtain From _____ Release To

Doctor/Hospital			
Address			
Phone Number		Fax	

_____ All medical records and/or information including those portions, if any, pertaining to HIV Testing, AIDS Diagnosis or treatment, Drug or Alcohol Abuse and treatment, or Psychiatric treatment.

_____ Specific Records Listed: _____

I understand that the medical records are confidential and cannot be disclosed without specific written consent of the person to whom they pertain or permitted by law. I further understand that once released, the record custodian, or its employees have no responsibility of liability that may arise regarding any suspect of this authorization.

I agree to accept responsibility for payment of any charges for the information requested. I understand fee charges are within the allowable by Florida Law. The copying fee is waived only when copies are for continuing medical care.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

ADVANCE DIRECTIVES

An advance directive is a written or oral statement about how you want medical decisions made should you not be able to make them yourself and/or it can express your wish to make an anatomical donation after death. Some people make advance directives when they are diagnosed with life-threatening illness. Others put their wishes into writing while they are healthy, often as part of their state planning.

Please indicate below any Health Care Advance Directives you have.

I, _____, have created the following Advance Directives.

_____ Living Will

_____ Health Care Surrogate Designation

_____ Anatomical Donation

_____ Other (please specify): _____

Please sign below to acknowledge that you have read and understand this information.

PATIENT NAME		DATE OF BIRTH	
PATIENT SIGNATURE		TODAY'S DATE	



AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

It is our policy to **NOT** release confidential and/or unauthorized information except appointment confirmation by home telephone answering machine, work telephone, voicemail, cell phone, and/or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an authorized person who may answer the phone.

With that in mind, many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you would like to have information released to someone other than yourself, please complete the following:

I authorize CLSC clinics to release my medical and/or billing information to the following individuals:

NAME	RELATION TO PATIENT	PHONE NUMBER

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

PATIENT NAME		DATE OF BIRTH	
PATIENT SIGNATURE		TODAY'S DATE	