# Bayfront Health Medical Group

Dear Patient,

Our practice is honored that you have chosen Bayfront Health Medical Group. You have chosen the best, most caring, most technologically advanced practice in Hernando and Pasco Counties and beyond! We strive to perform well above other offices you may have visited in the past, and we hope you will notice the many ways in which we are different. Everything we do is intended to efficiently deliver to you the best care possible, in a legal and ethical manner. Barring an emergency, your appointment will be on-schedule, so please be on time and turn in your paperwork as soon as possible. Please ask if you have questions regarding any of our policies or procedures.

Because we make every effort for your appointment to be at the scheduled time, it is very important that we receive these forms one week prior to your visit. If they are not returned complete before your appointment, it is possible that you will have to reschedule. Please fill in ALL blanks, whether or not they apply to you. We prefer that you fax the completed forms to the office you have selected, or you can mail to or drop off at any of our office locations. Please pay special attention to all policies listed, as you are agreeing to adhere to them.

**Completing Forms and Copying Charts**

There is a $20 charge for each disability, FMLA, or other medical form to be completed. We ask for 7 days to complete the form. To obtain a copy of your chart, you may incur a fee and we ask for 30 days to complete request.

**Deductibles and Refunds:**

If your deductible has not been met you will be responsible to pay at the time of service until the deductible is met. If there is an overlap in payments we will issue a refund upon request, or you may apply it to a future visit.

**Missed Appointments:**

There may be a **$25 charge for a missed appointment** unless you advise us one business day prior to your appointment. Being more than 15 minutes late is considered a late cancellation, and is subject to the same fee.

**Payment:**

Payment is due at the time services are rendered. Inability to pay at the time of your appointment may result in your appointment being rescheduled. If we are a contracted provider with your insurance company and are able to verify and confirm coverage, you will only be responsible for your co-pay and deductible at the time of your visit. Please note: Verification of coverage is not a guarantee of coverage. We suggest that you contact your insurance company to understand your benefits. You will be considered responsible for all visits, labs, and procedures not covered by your insurance.

**Percentages due (co-insurance):**

If your insurance policy only pays a percentage of your visit or surgery an estimate of your amount owed must paid the day of your visit or prior to your surgery. The percentage is based upon the allowed amount. If there is an over payment we will refund the difference to you upon request or it will be applied to future visits.

**Returned Check Policy:**

NSF checks or others returned to us will require complete payment in cash or certified funds for the amount of the check PLUS any fees allowed by Florida law.

**Your satisfaction with our care is our priority.** We are very excited to have you in our practice and look forward to our future relationship. By signing below, you are acknowledging a full understanding of the policies listed above.

Patient/Guardian Signature______________________________

Date______________________

## PATIENT'S REGISTRATION INFORMATION

First Name: ______________________ MI: ________ Last Name: ______________________

Date of Birth: ____________________

Street Address: ________________________________________________________________

City: ____________________________________ State: _______ Zip Code: ____________

Home Phone: ________________Cell Phone: ____________________ Work: ____________________

Email: _________________________ Social Security Number: XXX - XX - _ _ _ _

Race: ☐Black/African American ☐Other Race ☐Pacific Islander ☐Patient declined information ☐White or Caucasian

Ethnic Group: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Patient declined information

Emergency Contact: ______________________ Relationship: ______________ Phone: ___________________

Employer: _________________ Address: _____________________________ Phone: ___________________

Primary Physician: __________________________________

Preferred Pharmacy (with cross streets):____________________________________________________________

Mail Order Pharmacy: _________________________ Address: ________________________________________

Preferred Imaging Facility: ___________________________________________________________________

## INSURANCE INFORMATION – Please fill in ALL blanks.

Policy Holder's Name: _____________________________________ Date of Birth: ________________

Insurance Company: _________________________________________________________________

Insurance Claims Address: ____________________________________________________________

Insurance Company's telephone number: ___________________________________________________

Group/Policy #: __________________________ Subscriber/ID #: _____________________________

## Secondary Insurance Information- Please fill in ALL blanks or mark N/A

Policy Holder's Name: _____________________________________ Date of Birth: ________________

Insurance Company: _________________________________________________________________

Insurance Claims Address: ____________________________________________________________

Insurance Company's telephone number: ___________________________________________________

Group/Policy #: __________________________ Subscriber/ID #: _____________________________

ONLY IF PATIENT IS A MINOR – RESPONSIBLE PARTY INFORMATION – Please fill in ALL blanks.

First Name: ______________________ MI: ________ Last Name: ______________________

Sex: ☐ M ☐ F Date of Birth: __________________________ Phone: __________________________

Address: _________________________City: ________________ State: ________ Zip Code:__________

## Minor Pre-Authorization for Medical Care

I request and authorize Brooksville HMA, LLC and its personnel to deliver medical care to my child listed below.

Guardians Name (Print):_______________________ Guardians Signature: _____________________________

Relationship to patient (Print): __________________ Date: ________________

**Check, circle or fill in ALL answers (*you may mark more than one choice*). Please mark "None" if no other choice pertains to you.**

**Allergies to Medications and Reaction** ______________________________

______________________________

______________________________

______________________________

**Medications with dosages** ______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

**Vaccinations and Dates Completed**: ______________________________

______________________________

______________________________

______________________________

______________________________

**Gynecological History**

Frequency of cycle_____

Cramps- yes or no

Age when had 1st child____

Age menstrual cycle started___

Is flow-Light Moderate Heavy

Current birth control type__________

STD/PID- yes or no

Monthly menstrual cycle- yes or no

How many days cycle lasts_____

If Hysterectomy, reason_____________

If postmenopausal age at menopause___

Hormone Replacement Therapy- yes or no

Date of last menstrual period_________

Date of last mammogram____________

Date of last bone density____________

History of abnormal mammogram- yes or no

Fibroids of uterus- yes or no

Endometriosis- yes or no

Postmenopausal bleeding- yes or no

Sexually active- yes or no

Date of last Pap_________

Date of last Colonoscopy__________

History of abnormal pap- yes or no

Breast lump- yes or no

Total lifetime# of sexual partners______

History of ovarian cysts- yes or no

Sexual problems- yes or no

**Obstetrics History**

Total # of pregnancies____

Total # abortions induced_______

Total # ectopic_____

Total # full term_____

Total # abortions spontaneous___

Total # multiple births______

Total # premature_____

Total # living children______

**Past Pregnancies**

Baby #1 Date of birth________ # of fetuses______

Full term, premature, abortion induced, abortion spontaneous or ectopic Boy/Girl Weight_____

Delivery type- vaginal, c-section, other________________ Gestational weeks______

Preterm labor- yes or no Complications______________________________

Baby#2 Date of birth________ # of fetuses______

Full term, premature, abortion induced, abortion spontaneous or ectopic Boy/Girl Weight_____

Delivery type- vaginal, c-section, other________________ Gestational weeks______

Preterm labor- yes or no Complications______________________________

Baby#3 Date of birth________ # of fetuses______
Full term, premature, abortion induced, abortion spontaneous or ectopic Boy/Girl Weight_____
Delivery type- vaginal, c-section, other_________________ Gestational weeks______
Preterm labor- yes or no Complications________________________________________________

Baby#4 Date of birth________ # of fetuses______
Full term, premature, abortion induced, abortion spontaneous or ectopic Boy/Girl Weight_____
Delivery type- vaginal, c-section, other_________________ Gestational weeks______
Preterm labor- yes or no Complications________________________________________________

**Family Medical History** (any serious illness, for example, diabetes, heart problems, cancer...) **Please be sure to include below if you have an Aunt with breast or ovarian cancer**

Mom________________________________________________
Dad________________________________________________
Brother________________________________________________
Sister________________________________________________
Maternal grandmother ________________________________________
Maternal grandfather ________________________________________
Paternal grandmother ________________________________________
Paternal grandfather ________________________________________
Maternal Aunt ____________________________________________
Maternal Uncle ____________________________________________
Paternal Aunt____________________________________________
Paternal Uncle ____________________________________________
Other Relation ____________________________________________

## Social History

**Smoking/Tobacco Use**

☐Never ☐Former Smoker ☐ Current every day smoker ☐ Current some day smoker
Smokeless Tobacco Use- yes or no ____packs/can per day/week Years of Tobacco use____

**Marital status**

☐Married ☐Single ☐Divorced ☐Separated ☐ Widowed ☐Domestic Partner

**Alcohol use**

☐NONE ☐Occasional ☐Moderate ☐Heavy

**Drugs** Are you CURRENTLY using:
☐NONE ☐Marijuana/Spice ☐Heroin ☐LSD ☐Cocaine
☐Prescriptions abuse ☐Methadone

**Exercise**

☐ None ☐Occasional ☐Moderate ☐Heavy

**Diet**

☐Regular diet ☐Vegetarian ☐Vegan ☐Gluten Free ☐Specific ☐Low Carb
☐Cardiac ☐Diabetic

**Sexual or Physical Abuse**

☐NONE ☐Raped ☐Abuse as a child ☐Incest ☐Physical abuse in past
☐Physical abuse currently

**Sexual history**

Active with: ☐Heterosexual ☐Homosexual ☐Bisexual

**Surgery**

☐NONE ☐Appendix ☐Tonsils ☐Gallbladder ☐D&C
☐Abortion ☐Tubal ligation ☐Laparoscopy ☐Bladder suspension ☐Lumpectomy
☐Colon removed ☐Mastectomy ☐Hemorrhoidectomy ☐Hernia Repair ☐Orthopedic
☐Hysterectomy only ☐Hysterectomy + Ovaries ☐Other -

______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________

## Medical History

**Do you currently have or have you had any of the following**

☐NONE ☐Asthma ☐Atrial fibrillation ☐Adult onset diabetes
☐Anxiety ☐Arthritis ☐Breast cancer ☐BV (Bacterial Vaginosis)
☐Bipolar ☐Bronchitis ☐Bipolar disorder ☐Cancer (type) ____________
☐Chicken Pox ☐COPD ☐Compulsive disorder ☐Colon cancer
☐CMV ☐Depression ☐DVT ☐Elevated lipids
☐GERD ☐Glaucoma ☐Heart attack ☐Hypertension
☐Heart disease ☐Hepatitis B or C ☐HIV/AIDS ☐Hypothyroidism
☐Infertility ☐Kidney disease ☐Kidney Infection ☐Kidney Stones
☐Lung cancer ☐Liver disease ☐Measles ☐Melanoma
☐Migraines ☐Osteoporosis ☐Osteoarthritis ☐Rheumatic fever
☐Seizures ☐Mitral valve prolapse ☐Neurological disorder ☐PMS/PMDD
☐Sleep Disorder Insomnia ☐Suicide attempt ☐Urinary tract infections
☐Yeast Infection

- ☐ Endocrine Problems
- ☐ Hematologic/Lymphatic Problems
- ☐ Allergic/Immunologic Problems

**Accidents/Hospitalization**

☐No injuries ☐Car accident ☐Motorcycle ☐Head injury
☐Fracture ☐OB only ☐Illness____________________

Other:_________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________

All portions of this form ***must*** be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

| Patient's Name | | | | Date of Birth | Medical Record Number |
|---|---|---|---|---|---|
| Address | City | State | Zip | Telephone Number | Email Address |

I authorize the use and disclosure of health information about me as described below:

| Facility Authorized to Release my Health Information | | | | |
|---|---|---|---|---|
| Address | City | State | Zip | Telephone Number |
| Agency or Individual(s) Authorized to Receive my Health Information | | | | |
| Address | City | State | Zip | Telephone Number |

Health Information that may be used / disclosed is limited to the following:
☐ Progress Notes ☐ Emergency Room Record
☐ Discharge Summary ☐ History and Physical ☐ Consultation(s) ☐ Lab ☐ Pathology Report
☐ Operative Note(s) ☐ Imaging/X-Ray Films ☐ X-Ray Reports ☐ Entire Record ☐ Fetal Heart Monitor Strips
**Sensitive Information:** ☐ Alcohol Abuse ☐ Drug Abuse ☐ Communicable diseases, including HIV status
☐ Genetic Testing ☐ Psychiatric/Behavioral Diagnoses
☐ Other *(specify)* ____________________

Health Information that may be used / disclosed is limited to the following periods of healthcare:
From (date): ____________ To (date): ____________ Account Number: ____________
From (date): ____________ To (date): ____________ Account Number: ____________

Health information to be released to the above named agency / individual is to be used / disclosed for the following purpose(s):
☐ Treatment/Consultation ☐ At Request of Patient ☐ Research ☐ Marketing ☐ Billing or Claims Payment
☐ At Request of Employer ☐ Other ____________________

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, X-Ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, including Sensitive Information as indicated above, which was compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

If no specific date or event is noted below, this authorization will automatically *expire 60 days* after the date of signature. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the HIPAA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with (HIPAA) privacy regulations.

| Patient's Signature or Legal Representative | | | Date/Time |
|---|---|---|---|
| Relationship to Patient / Authority to Act on Patient's Behalf | | Interpreter, if Utilized | Date/Time |
| Witness Signature | Date/Time | Expiration Date or Event | |

☐ **Signature validated against driver's license or signature in Medical Record. There may be a charge for copying Medical Records.*
☐ Electronic copy requested.

Authorization to Use and Disclose
Protected Health Information
HIM-1401



(Revised 11/10, 02/12, 05/14, 08/14, 04/15, 09/16, 04/17, 01/18)

Patient Label

Bayfront Health

1. **ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:**
   I hereby assign and authorize payment directly to the Physician Clinic all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this Physician Clinic, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for any charges not covered by my insurance company.
   I understand that I am obligated to pay the account of the Physician Clinic in accordance with the regular rates and terms of the Physician Clinic. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Physician Clinic visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for the Physician Clinic to work with my insurance company/ companies on my behalf on authorization, appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.
2. **PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):**
   I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information. I have been provided the Electronic Prescribing Notice.
3. **CONSENT TO RELEASE HEALTH INFORMATION:**
   I understand this Physician Clinic uses an electronic medical record. I understand that the electronic medical record contains information about my health from my past, current and future health care providers. I agree that this health information may be released through the Physician Clinic's electronic medical record or by other means (for example, fax, telephone, email, or hand delivery): (1) to the Physician Clinic; (2) to my past, current and future health care providers and other health care organizations that provide care to me; (3) to the health insurance company named in my medical record; and (4) to any other person named in my medical record who pays for my treatment. These people may use my health information: (1) to treat me; (2) to get paid for my treatment (for example, billing insurance companies), and (3) to do health care operations activities (for example, managing my care, providing quality care, patient safety activities, and other activities necessary to run the Physician Clinic). I understand that these people will have access to all my health information in the medical record, including behavioral health and substance use disorder information (for example, drug and alcohol treatment), my medical history, diagnosis, hospital records, clinic and doctor visit information, medications, allergies, lab test results, radiology reports , sexual and reproductive health information, communicable disease-related information (for example, sexually transmitted diseases), and HIV/AIDS-related information. I understand that I may take back this consent at any time, except if my health information has already been released to someone. I also understand that I may request a list of the health care organizations that have received my substance use disorder information. This consent will expire one year after my death.
4. **NOTICE OF PRIVACY PRACTICES:**
   Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Physician Clinic's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information, including information generated through use of virtual health or telemedicine services, as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Physician Clinic, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.
5. **GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES:**
   I have been informed of the treatment procedures considered necessary for me and that the treatments/ procedures will be directed by a physician or independent Advanced Practitioner, in accordance with state laws, scope of practice, and licensure of medical staff.
6. **CONSENT FOR VIRTUAL HEALTH/TELEMEDICINE SERVICES:**
   I hereby consent to engaging in virtual health or telemedicine services, where available, as part of my treatment. I understand that "virtual health" or "telemedicine services" includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications when the health care provider and patient are not in the same physical location.
   The interactive electronic systems used for these services will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.



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I understand that the potential benefits of receiving care in this manner include improved access to care and the ability to obtain the expertise of a distant specialist. The potential risks include problems with information transmittal, including but not limited to poor data transfer which may include a poor video and data quality experience, or lack of access to my complete medical record by the remote physician. I understand that all information, including images, will be part of my medical record available to me if requested and with the same restrictions on dissemination without my consent. I understand I may withdraw my consent at any time.

7. **ADVANCE DIRECTIVE ACKNOWLEDGEMENT:**

Federal law requires that patients be provided information about their rights to make advance health care decisions, including Living Will, Durable Medical Power of Attorney or designation of surrogate decision made for health care decisions. If you have already completed any of these documents, please inform your physician and the Physician Clinic.

***Please check one:***

- ☐ I have executed an advance directive and have supplied a copy to the Physician Clinic.
- ☐ I have executed an advance directive and have been requested to supply a copy to the Physician Clinic.
- ☐ I have reviewed the directive(s) on file with this Physician Clinic and it is/they are my current directive(s).
- ☐ I have not executed an advance directive. I have received information about advance directives from this Physician Clinic.
- ☐ I have not executed any advance directives, and I do not wish to receive information about advance directives from this Physician Clinic

8. **RESEARCH STUDIES:**

Are you currently a participant in any research study or project: *(If yes, please briefly describe what is being studied (drug, medical device or other)* ______________________

Who can the Physician Clinic contact with questions about the Study? ______________________

9. **CONSENT TO PHOTO/VIDEO:**

I consent to the photographing, videotaping and/or video monitoring, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

10. **CONSENT TO PHOTOGRAPH AT THE TIME OF REGISTRATION:**

I, or my authorized legal representative, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's ambulatory medical record electronically as my photo identification.

11. **E-MAIL:**

I hereby consent to provide my e-mail address, so that representatives from the Physician Clinic can e-mail information to me about health education or disease prevention and up-to-date information about the Physician Clinic, its affiliated physicians, and our services. I understand I will be able to change my preference at any time.

Email Address:

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

12. **CELL PHONES:**

I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from the Physician Clinic, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by e-mailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

13. **VIDEOTAPING/RECORDING:**

I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to. I have struck through and initialed the section that does not have my consent or permission.

| | | | |
|---|---|---|---|
| Patient's Signature or Legal Representative | | | Date/Time |
| Relationship to Patient | | Interpreter if Utilized | Date/Time |
| Witness Signature | Date/Time | If Telephone Consent Second Witness Signature | Date/Time |



Patient Label

| Patient's Name | Date of Birth | Medical Record Number | |
|---|---|---|---|
| Patient Street Address | City | State | Zip |
| Home Telephone Number | Work Telephone Number | | |

I give permission to VERBALLY discuss the following medical information about me (check all boxes that apply):

- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Lab/test results
- ☐ Other (describe):
- ☐ Other (describe):

The physician practice has my permission to discuss the above information with:

1. ______________________________
Name/Relationship to Patient

______________ ______________ ______________ ______________
Street Address City State Zip

______________ ______________
Home Telephone Number Work Telephone Number

2. ______________________________
Name/Relationship to Patient

______________ ______________ ______________ ______________
Street Address City State Zip

______________ ______________
Home Telephone Number Work Telephone Number

I understand that I have the right to revoke my permission at any time, except where the physician practice has already made disclosures in reliance upon this request. **I understand that I must notify the physician practice in writing if I want to revoke my permission.**

| Patient's or Authorized Personal Representative's Signature | | | |
|---|---|---|---|
| Relationship to Patient / Authority to Act on Patient's Behalf | Interpreter, if Utilized | Date | Time |
| Witness Signature | Expiration Date or Event | Date | Time |

If authorized representative, please sign and attach copies of supporting legal documentation. Reason patient unable to sign:

______________________________

______________________________

The physician practice knows that privacy regulations have an impact on our customer services to you, especially when it comes to discussing information about you with family, friends and others you designate who are involved in your care. We have established a process that allows you to tell us who we may talk with about your medical care.

**How can I give others permission to get verbal information about me?**
Complete the Permission to Verbally Discuss Protected Health Information form on the 1st page to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss.

**How is the information on the form used?**
Anytime your designated person calls or makes a request on your behalf, we will verify the individual has your permission to receive the information and then we will share the information.

**What are some examples of when this might be useful?**

- If an elderly parent wants an adult child to help understand medical treatment instructions
- If a friend is helping an elderly patient with health issues
- If a college student wants information shared with a parent

**Can the person I designate also get copies of my medical records?**
No they can only receive verbal information. To get copies of medical records, you must complete a separate Authorization form available at our Physician Practice(s).

**What if I change my mind?**
You can change or revoke (stop) this process at any time by writing to us at the address shown below. Forms are available at your Physician Practice(s), or you can obtain a new form from the Physician Practice(s).

**What happens if I don't complete this form?**
We will continue to protect your private health information as required by law.

Physician Practice Name

Street Address | City | State | Zip

Telephone Number | Fax Number

## Notice of Communication Accessibility Services

Our staff wants to communicate effectively with you and your family members. Please fill out this paper and return it to Registration Clerk or your Nurse.
All of the communication accessibility aids and/or services that you need are **free of charge to you.**

| **Do you think you need any of the following aids and/or services?*** | **YES** | **NO** |
|---|---|---|
| American Sign Language interpreter | | |
| Oral interpreter | | |
| TTY/TDD | | |
| Hearing-aid compatible telephone receiver with volume control | | |
| Television closed captioning | | |
| Written/printed materials in other formats (i.e. large print, audio, accessible electronic or other formats as available) | | |
| Written/printed materials in Braille (if available). Other alternatives will be made available to accommodate individuals who are blind or have limited vision. | | |

Additional aids and/or services may be available. Please list any other ways we may better communicate with you:

*Please note that some aids or services will only be necessary in certain situations.

I understand that this healthcare facility will not pay for any aids and/or services that I choose to provide *on my own.* I also understand that I can change my mind at any time and request that this healthcare facility provide aids and/or services at no charge to me.

Primary Spoken Language: ______________________________
Patient's preferred language for discussing healthcare: ______________________________
Interpreter services are available 24 hours per day.
Some Limited English Proficiency (LEP) persons may prefer or request to use a family member or friend as an interpreter. However, family members of friends of the LEP person will not be used as interpreters unless specifically requested by that individual and **after** the LEP person has understood that an offer of an interpreter at no charge to the person has been made. Such an offer and the response will be documented in the patient's medical record. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services using the applicable CyraCom services will be provided to the LEP person.
Children and other clients/patients will **not** be used to interpret, in order to ensure confidentiality of information and accurate communication.

This provider complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-352-796-5111 (TTY: 1-1-800-955-8771).

Este proveedor cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-352-796-5111 (TTY: 1-800-955-8771).

Founisè sa konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks.
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-352-796-5111 (TTY: 1-800-955-8771).

| Patient/Family Member/Companion Signature | Date/Time |
|---|---|
| Signature of person, *if any*, who filled out this form on behalf of the patient, family member, or companion: | Date/Time |
| Witness | Date/Time |



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