TAMPA FAMILY HEALTH CENTERS

Your Patient Centered Medical Home

Phone: (813) 397-5300 | www.tampafamilyhc.com

REGISTRATION FORM

1) Name (*First and Last*): _____ M.I.: __ Date of Birth: _____

2) Address: _____ State: _____ Zip Code: _____

3) Home Phone: _____ Cell Phone: _____ Work Phone: _____

4) SSN: _____ Email: _____

5) Primary Language: ☐ English ☐Spanish ☐Other: _____

6) Race *(check all pertinent)*	7) Ethnicity	9) Birth Sex	11). Gender Identity
☐Asian ☐American Indian ☐Black/African American ☐Native Hawaiian ☐Other Pacific Islander ☐White ☐Don't want to disclose	☐Hispanic/Latino/Spanish ☐Non-Hispanic/Latino **8) Marital Status** ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Partner	☐Male ☐Female **10). Sexual Orientation** ☐Straight ☐Lesbian/Gay ☐Bisexual ☐Something else ☐Don't know ☐Don't want to disclose	☐Male ☐Female ☐Transgender M to F ☐Transgender F to M ☐Other ☐Don't want to disclose

12) Household size*: _____ Household Income (before taxes): _____ per ☐Yearly ☐Monthly

*Household size – number of individuals supported by the household income/dependents

13) Employer: _____Employer phone: _____Occupation: _____

14) Agricultural worker: ☐No ☐Yes, Type**: _____☐Chose not to disclose

**Types of agricultural worker status:

- Migratory Agricultural worker – within 24 months of your visit, you have left the community to work elsewhere
- Seasonal Agricultural worker – within 24 months of your visit, you are/were paid to work piecework, hourly, daily wages in a season

15) Homeless Status: ☐No ☐Yes, Type***: _____☐Chose not to disclose

***Types of homeless status:

- Homeless Shelter – You live in an organized shelter for homeless persons
- Transitional Housing – You live in a small unit that helps you transition from homelessness to permanent housing
- Doubling up – You live with other individuals in their home/apartment
- Street – You live outdoors (car, encampment "tent city", makeshift housing, shelter)
- Permanent Supportive Housing –You live in a housing unit that provides community-based support and resources
- Other – You live in a single room occupancy, motel, hotel, day to day paid housing.

16) School-based health center	17) Veteran Status:	18) Public Housing:
☐No ☐Yes ☐Chose not to disclose	☐No ☐Yes ☐Chose not to disclose	☐No ☐Yes ☐Chose not to disclose

19a) Primary Medical Insurance: _____ Member ID: _____

19b) Secondary Medical Insurance: _____ Member ID: _____

19c) Dental Insurance: _____Member ID: _____

19d) Secondary Dental Insurance: _____ Member ID: _____

20) Preferred Pharmacy****: _____ Address: _____ Phone: _____

**** TFHC Pharmacy will be listed as your preferred pharmacy if no pharmacy information is provided.

Emergency Contact Information	Parent/Legal Guardian information(*patient is under 18 yo*)
Name:_____	Name:_____
Phone: _____	Phone:_____
Relationship: _____	Relationship: _____
★_____ **Patient/Parent/Legal Guardian Name (Print)**	_____/__/__ **Patient/Parent/Legal Guardian Signature and Date**

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ADULT HISTORY FORM

Name (*First and Last*): _____ Date of Birth: _____

Language (*Primary language*): _____Need translator? ☐Yes ☐No

What is the purpose of your visit today? _____

Allergies

Food: _____ Reaction? _____

Drug/Medication: _____ Reaction? _____

Other: _____ Reaction? _____

Medications *(Prescription and Over-the-counter)*

_____ Dose: _____ for _____ x a day

_____ Dose: _____ for _____ x a day

_____ Dose: _____ for _____ x a day

_____ Dose: _____ for _____ x a day

_____ Dose: _____ for _____ x a day

_____ Dose: _____ for _____ x a day

Obstetrics and Gynecology History: FOR WOMEN ONLY

Age of onset of period: _____ Last menstrual period: _____ Length of period: _____days

History of abnormal pap smear? ☐No ☐Yes History of abnormal mammogram? ☐No ☐Yes

History of abnormal bleeding? ☐No ☐Yes History of abnormal discharge? ☐No ☐Yes

History of pelvic pain? ☐No ☐Yes History of urine leakage? ☐No ☐Yes

Pregnancies: _____ Live births: _____ Miscarriages: _____ Abortion: _____

Family History *(Check all that apply)*

	Father	Mother	Fathers parents	Mothers parents	Siblings	Children
Cancer, specify: _____						
Diabetes						
Epilepsy/Convulsions						
Glaucoma						
Heart Disease						
High blood pressure						
Mental Illness						
Thyroid Disease						

Social History

History of smoking: ☐Never smoked ☐Yes, but quit for ___ years ☐Yes, I still smoke. Sticks a day? _____

History of drug-use? ☐Never. ☐Yes. But quit for ___years ☐Yes, _____ times a week.

Drink alcohol: ☐No ☐Yes. _____bottles a week.

Sexual History: Are you sexually active? ☐No ☐Yes Sex with the different partner/s w/in 12 months? ☐No ☐Yes

Sex with the same gender w/in 12months? ☐No ☐Yes Sex with the opposite gender w/in 12 months? ☐No ☐Yes

Sex with person/s of HIV risk w/in 12months?☐No☐Yes. Have you ever had a positive HIV test? ☐No ☐Yes

Had HIV preexposure prophylaxis before? ☐No ☐Yes Result of previous HIV test?☐Positive ☐Negative ☐Don't know

Have you ever been a victim of sexual assault? ☐No ☐Yes

Do you feel afraid of your partner? ☐No ☐Yes

Have you been in a relationship in which you have been physically hurt? ☐No ☐Yes

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Name (*First and Last*): _____ Date of Birth: _____

Hospitalization and Surgical History *(List of hospitalization reason/operations and date)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

Past Medical History *(Check all that apply)*

☐Asthma	☐Alcohol-Related disorders	☐Anxiety	☐Blood disorders	☐Cancer
☐Diabetes	☐Depression	☐Hepatitis A	☐Hepatitis B	☐HIV
☐Heart Disease	☐High blood pressure	☐Thyroid disease	☐Tuberculosis	
☐Sexually Transmitted Disease		☐Substance-related disorders		

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE
ADVANCE DIRECTIVES

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statues, please answer the following:

Declaration to Decline Life-Prolonging Procedure (Living Will)

☐ I have made such declaration.

☐ I have NOT made such a declaration.

Health Care Surrogate

☐ I have designated a Health Care Surrogate

☐ I have NOT designated a Health Care Surrogate

Durable Power of Attorney

☐ I have appointed a Durable Power of Attorney for Health Care decisions

☐ I have NOT appointed a Durable Power of Attorney for Health Care decisions

☐ I decline to answer the above questions.

★ _____ _____

Signature over Printed Full Name Date

CONSENT FOR TREATMENT

I, myself/patient, hereby give consent and authorize treatment at Tampa Family Health Centers, Inc.

★ _____ _____

Signature over Printed Full Name Date

Residents and Students Assisting in my Health Care

I understand that TFHC supports the education of medical professionals and maintains Residents and Students that may assist in my health care.

☐ Yes, I consent to Residents and Students to assist in my health care

☐ No, I refuse to Residents and Students to assist in my health care

★ _____ _____

Signature over Printed Full Name Date

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PATIENT CONSENTS AND ACKNOWLEDGEMENTS

TFHC as my Patient Centered Medical Home

I, patient/parent/legal guardian, choose to participate in the patient-centered medical home. ☐No ☐Yes

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received the Tampa Family Health Center's (TFHC's) Notice of Privacy Practices, which describes the ways in which TFHC may use and disclose my healthcare information for treatment, payment, healthcare operations and/or other described and permitted uses and disclosures. I understand that I may contact the Compliance Officer if I have any questions or complaints. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the TFHC's Notice of Privacy Practices. ☐No ☐Yes

Authorization for Release of Medical Information ☐No ☐Yes

- 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 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 psychiatric conditions, psychological 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 TFHC and the physicians or other health professionals involved in my care to release healthcare information for purpose of treatment, payment and/or healthcare operations.

Authorization for Disclosure to Family and/or Friends ☐No ☐Yes

I give permission for my Protected Health Information to be disclosed for coordinating health care needs, communicating results, findings and care decisions to the family and/or friends listed:

Name	Relationship	Contact Number

**The patient has the right to revoke disclosure to these individuals any time by completing a new consent form with new information.*

Consent for Use and Disclosure of Protected Health Information (PHI)

- May we call/text your home and leave a message? ☐No ☐Yes
- May we call/text your cell and leave a message? ☐No ☐Yes
- May we call/text your work and leave a message? ☐No ☐Yes

Consent to Email or Text Message for Appointment Reminders and other health communications ☐No ☐Yes

- I hereby give consent and authorize TFHC to contact me via email and/or text messaging to remind me of an appointment, obtain feedback on my experiences with the healthcare team, or to provide general health reminders and communication. I will provider an email or text information at which I may be contacted.
- I consent to receive TEXT messages at mobile number (_____) and/or email at email address: (_____) for appointment reminders, feedbacks, and general health communication.
- TFHC will not charge for this service, but standard test messaging and data rates may apply as provided in your wireless plan (Contact your carrier for pricing plans and details).

★_____ _____

Signature over Printed Full Name Date

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Name (*First and Last*): _____ Date of Birth: _____

FINANCIAL OBLIGATION FORM A

TFHC wants to continue providing quality and sustainable medical services to the community. To accomplish our mission, TFHC and patients have obligations to each other for continued affordable medical services. TFHC offers Sliding Scale Discounts to financially challenged and responsible patients.

Primary Insurance: _____ Member ID: _____

Dental Insurance: _____ Member ID: _____

I have an "In-Network" Insurance/Medicare/Medicaid/Commercial/Hillsborough County Health Plan:

- I am responsible for paying the co-pay every check-in during my medical visit, if applicable.
- I am responsible for charges associated with non-covered services.
- I am responsible for the balances from processed insurance claims.
- I am responsible for making payment, or for arranging a payment plan, within 30 days of the date that appears on my billing statement.
- I understand that a financial counselor will be available if I have difficulty paying my bill.
- I am aware that failure to pay my bill will result in a TFHC Self Pay Specialist contacting me to collect the remaining balance or set up a payment plan.

_____ _____

Signature over Printed Full Name Date

I have an "Out of Network" Insurance;

- I am responsible for paying the co-pay every check-in during my medical visit, if applicable.
- I am responsible for "out of network" charges from my insurance.
- I am responsible for charges of non-covered services
- I am responsible for balances from processed insurance claims.
- I am responsible for making payment, or for arranging a payment plan, within 30 days of the date that appears on my billing statement.
- I understand that since I am "Out of Network," I may not receive other medical services such as referrals, case management, therapies, durable medical equipment, etc.
- I understand that a financial counselor will be available if I have difficulty paying my bill.
- I am aware that failure to pay my bill will result in a TFHC Self Pay Specialist contacting me to collect the remaining balance or set up a payment plan.

★_____ _____

Signature over Printed Full Name Date

I have no insurance (See Financial Obligation Form B)

- I am responsible for Sliding Scale Discount (Form B) based on my household income.

_____ _____

Signature over Printed Full Name Date

Credit Card Opt-in/Optout

I authorize TFHC to charge my credit card to cover for any medical or dental services not covered by my insurance.

☐ Yes. I opt in and authorize TFHC to charge my credit card for any noncovered medical or dental services.

☐ No. I opt out to have TFHC charge my credit card for any non-covered medical and dental services.

_____ _____

Signature over Printed Full Name Date

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Name (*First and Last*): _____ Date of Birth: _____

FINANCIAL OBLIGATION FORM B - Sliding Scale Discount

TFHC offers Sliding Scale Discounts to financially challenged and responsible patients. TFHC incorporated Sliding Scale Discount based on your household income for medical service payments

Sliding Scale A: You are required to pay $15.00 deposit only and may qualify for Hillsborough County plan or Medicaid. You are receiving a 100% discount for medical services.

Sliding Scale B: You are responsible for $20.00 deposit at the time of your medical visit AND 25% of your total medical bill. This $20.00 deposit will be counted towards the 25% of your total bill. You are receiving a 75% discount for medical services, but you are still responsible for the remaining amount on the final bill. **

Sliding Scale C: You are responsible for $30.00 deposit at the time of your medical visit AND 50% of your total medical bill. This $30.00 deposit will be counted towards the 50% of your total bill. You are receiving a 50% discount for medical services, but you are still responsible for the remaining amount on the final bill. **

Sliding Scale D: You are responsible for $40.00 deposit at the time of your medical visit AND 75% of your total medical bill. This $40.00 deposit will be counted towards the 75% of your total bill. You are receiving a 25% discount for medical services, but you are still responsible for the remaining amount on the final bill. **

Sliding Scale E: You are responsible for $50.00 deposit at the time of your medical visit AND 100% of your total medical bill. This $50.00 deposit will be counted towards the 100% of your total bill, but you are still responsible for the remaining amount on the final bill. **

Immunization Fees. Charges for immunizations are NOT subject to sliding scale discounts. Full fees are applied to all immunizations.

**Requirements to stay in Sliding Scale Discount:

1. *Every year.*
   Proof of income (one full month worth) as soon as possible. If TFHC does NOT receive your proof of income by the third visit, you are advised to see a TFHC Financial Counselor. Otherwise, you will be placed on Sliding Scale E. You will be responsible for $50.00 deposit and 100% of your final medical bill.
2. *Every office visits.*
   Monetary deposits will be collected when you check in for your appointment. You are required to pay the appropriate deposit for your sliding scale when you check in. After the visit, there may be additional charges depending on the medical and laboratory services rendered. You are still responsible for the remaining amount on your final bill. The remaining balance will be due before your next visit. If you have concerns, TFHC encourages you to see our financial counselors.

☐ Yes. I understand my Financial Obligation as outlined in Form B as a patient of TFHC.
☐ No. I refuse to pursue my Financial Obligation as outlined in Form B for TFHC.

★_____ _____

Signature over Printed Full Name Date