FLORIDA TECH

NEW PATIENT INFORMATION

PATIENT	INSURED PARTY
Last Name ____________	Company ____________
First Name ____________	Policy No. ____________
Email Address ____________	Group No. ____________
Florida Tech Mailbox Number ____________	Policy Holder ____________
Address ____________	Policy Holder DOB ____________
City ____________	Phone ____________
State ____________ ZIP ____________	
Cell or Home Phone ____________	
Student ID/SSN ____________	
Employer ____________	
Work Phone ____________	
Date of Birth ____________	
Emergency Contact Name ____________	Phone ____________

Primary Care Physician ____________

Race: ❏ White ❏ American or Alaska Native ❏ Asian ❏ Black or African American ❏ Native Hawaiian or other Pacific Islander ❏ Other

Ethnicity: ❏ Non Hispanic ❏ Hispanic or Latino

Marital Status: ❏ Single ❏ Married ❏ Separated ❏ Divorced ❏ Widowed

Consent for Treatment: The undersigned authorizes the Florida Tech O.A. Holzer Health Center to provide treatment including X-rays, blood withdrawal, local anesthesia, intravenous solutions and the performance of which the provider considers necessary and proper in the treatment of the above named patient.

Cancellation/ No Show Policy: I, the undersigned, understand the Health Center requires a 24 hours' notice of cancellation. Patients who repeatedly cancel or do not show for their schedule appointments may lose eligibility for services and may be referred to an off-campus provider.

Release of Records: I hereby authorize the provider to furnish insurance companies with any information concerning my treatment that may be requested, including photocopies from my patient records as necessary for completion of my claim or as may be requested by law. I further authorize the provider to furnish information from my records pertaining to the treatment as requested by other doctors or medical care facilities for continued care and treatment.

Payment Agreement: I, the undersigned, understand that I am responsible for all charges for treatment received regardless of insurance coverage. I understand that the provider cannot accept responsibility for collecting any insurance claim or negotiating any settlement on a disputed claim. Provider reserves the right to decline further services to the patient for non-payment. Patient accounts are due at the time treatment is given unless other arrangements are made in advance. A charge of $27.50 will be charged on all RETURNED CHECKS.

I, the undersigned, assign benefits payable for physician services to the physician or organization furnishing the services and authorize the physician group/organization to submit a claim to my health insurance carrier on my behalf.

Signature of patient (or parent, if a minor) ____________ Date ____________

Florida Institute of Technology ▪ Holzer Health Center ▪ 150 W. University Blvd., Melbourne, FL 32901-6975 ▪ 321-674-8078 ▪ Fax 321-725-5967

HOLZER STUDENT HEALTH CENTER POLICY

I understand that any procedures, in-clinic testing, laboratory/blood work or X-rays will be billed to my personal health insurance. This includes in-clinic testing for urinary tract infections, strep throat, pregnancy, influenza and mononucleosis. I am financially responsible for any medical services not covered by my health insurance. I acknowledge that the insurance information I have provided is accurate and complete to the best of my knowledge.

I understand it is my responsibility to know the coverage and limitations of my own insurance, whether it is through my parents or the university.

Signature____ Date_______________

UNITED HEALTHCARE—STUDENT RESOURCES (STUDENT HEALTH INSURANCE PARTICIPANTS)

Your insurance requires a deductible each academic year (i.e., patient is responsible for the first $75 of medical expenses). Please call United Healthcare insurance company for more information or access **uhcsr.com** for Florida Tech student health insurance information.

Signature____ Date_______________

Your Florida Tech student health insurance representative can be reached at 321-674-8080. We encourage you to consult your student medical plan for further information regarding coverage and exclusions before calling. A student health insurance booklet is available online.

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FLORIDA TECH

HEALTH HISTORY

Name ______________________________ Birth Date ______________________________

List of current medications

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Allergies to medications ______________________________ ______________________________

List previous surgeries/hospitalizations ______________________________ ______________________________

______________________________ ______________________________

Have you had a history of any of the following:

- ❏ Headaches
- ❏ Seizures
- ❏ Anemia
- ❏ Tuberculosis
- ❏ Skin Problems
- ❏ Sickle Cell Disease
- ❏ Heart Problems
- ❏ Liver Disease
- ❏ Urinary Problems
- ❏ STDs
- ❏ Anorexia
- ❏ Depression
- ❏ Eye Problems
- ❏ Blood Clots
- ❏ Diabetes
- ❏ Stomach/Bowel Problems
- ❏ High Blood Pressure
- ❏ Asthma/Lung Problems
- ❏ Cancer
- ❏ Gall Bladder Disease
- ❏ Allergies
- ❏ Blood Disease
- ❏ Bulimia
- ❏ Anxiety

Additional concerns ______________________________

____

Have you ever been treated for mental illness or emotional problems? ❏ Yes ❏ No

Do you use Tobacco? ❏ Yes ❏ No Alcohol? ❏ Yes ❏ No Drugs? ❏ Yes ❏ No

Has anyone hit you or struck you in the last 18 months? ❏ Yes ❏ No

Are there any diseases that run in your family? ❏ Yes ❏ No If yes, please list ______________________________

____

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Consent to the Use and Disclosure of Health Information for Treatment, Payment or Health Operations

I, ________________________________ *(patient name)*, understand that as part of my health care, this practice originated and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatments and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to use or disclosure of my health information____

____

____

I fully understand and ❏ accept ❏ decline the terms of this consent.

Signature of patient or legal representative ____ Date__________________________

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CONSENT FOR COMMUNICATION AND/OR DISCLOSURE

I request the following alternatives or limitations relating to communications directed to me by my health care provider or employee of PREMIER PRIMARY CARE.

Do we have your permission to call you at home or at the number you have given? ❑ Yes ❑ No

If yes, may we leave the following information on your answering machine or voice mail?
Appointment Information ❑ Yes ❑ No
Billing Information ❑ Yes ❑ No
Medical Information ❑ Yes ❑ No

May we call you at work? ❑ Yes ❑ No
If yes, may we leave the following information on your work answering machine or voice mail?
Appointment Information ❑ Yes ❑ No
Billing Information ❑ Yes ❑ No
Medical Information ❑ Yes ❑ No

I give my permission to share the following information with the person(s) named below:

Name ____________________ Relationship ____________________
Appointment: ❑ Yes ❑ No Billing: ❑ Yes ❑ No Medical: ❑ Yes ❑ No

Name ____________________ Relationship ____________________
Appointment: ❑ Yes ❑ No Billing: ❑ Yes ❑ No Medical: ❑ Yes ❑ No

Name ____________________ Relationship ____________________
Appointment: ❑ Yes ❑ No Billing: ❑ Yes ❑ No Medical: ❑ Yes ❑ No

Name ____________________ Relationship ____________________
Appointment: ❑ Yes ❑ No Billing: ❑ Yes ❑ No Medical: ❑ Yes ❑ No

Patient Signature ______________________________ Date ______________

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