FLORIDA TECH

# NEW PATIENT INFORMATION

## PATIENT

Last Name_____

First Name_____

Email Address_____

Florida Tech Mailbox Number _____

Address _____

City _____

State_____ ZIP_____

Cell or Home Phone_____

Student ID/SSN _____

Employer _____

Work Phone_____

Date of Birth _____

Emergency Contact Name_____

## INSURED PARTY

Company _____

Policy No. _____

Group No._____

Policy Holder _____

Policy Holder DOB _____

Phone _____

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 Holzer Health Center to provide treatment including blood withdrawal and local anesthesia.

**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. Outstanding balances greater than $100 for more than 90 days may be subject to a hold being placed on my student account.

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_____

Premier Primary Care



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## 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.
Initial _____

LABORATORY SERVICES: I acknowledge that certain lab tests may be sent to an independent lab for processing and hereby authorize results from these labs to be electronically delivered to Holzer Health Center. I understand that I will receive a separate bill for test results processed by an independent lab and agree to be financially responsible for the lab services provided to me that are not covered by insurance.
Initial _____

Signature_____ Date_____



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# 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 | ❑ Eye Problems |
| ❑ Seizures | ❑ Blood Clots |
| ❑ Anemia | ❑ Diabetes |
| ❑ Tuberculosis | ❑ Stomach/Bowel Problems |
| ❑ Skin Problems | ❑ High Blood Pressure |
| ❑ Sickle Cell Disease | ❑ Asthma/Lung Problems |
| ❑ Heart Problems | ❑ Cancer |
| ❑ Liver Disease | ❑ Gall Bladder Disease |
| ❑ Urinary Problems | ❑ Allergies |
| ❑ STDs | ❑ Blood Disease |
| ❑ Anorexia | ❑ Bulimia |
| ❑ Depression | ❑ 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 contact you by email? ❑ Yes ❑ No

If yes, may we provide the following information on your email?

Appointment Information ❑ Yes ❑ No

Billing Information ❑ Yes ❑ No

Medical Information ❑ Yes ❑ No

***Please Note: Emails sent over the internet are not necessarily secure. Florida Tech Holzer Health Center cannot guarantee the confidentiality or security of any information sent over the internet when using email. The Florida Tech Holzer Health Center shall not be liable for any breach of confidentiality resulting from such use of email.***

**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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