CARE POINT
Health & Wellness Center

PATIENT REGISTRATION

Patient Information

_____

First Middle Initial Last

_____

Date of Birth Social Security # Driver's License #

_____

Address City ST Zip

_____

Home Phone Cell Phone Work Phone

I give my permission for Care Point to call/text me on my cell phone and leave messages. ☐ Yes ☐ No
I understand I will receive an email invitation for the patient portal Follow My Health

Email:_____ Patient is: ☐ Responsible Party ☐ Policy Holder

Sex: ☐ Female ☐ Male ☐ Transgender **Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired ☐ Unemployed
Student Status: ☐ Full Time ☐ Part Time ☐ NA Preferred Pharmacy:_____
Language: ☐ English ☐ Spanish ☐ Other
Race (optional): ☐ American Indian/Alaskan Native ☐ Asian ☐Black or African American ☐More than one race
☐Native Hawaiian ☐Other Pacific Islander ☐Refused to Report/Unreported
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐Refused to Report/Unreported

Insurance Information

Name of Insured:_____Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Insurance:_____Secondary:_____

Employer Name:_____Employer ID:_____

Insurance ID#_____Medicaid ID#_____

If Bend Bend Cares client, name of Case Worker:_____

How did you hear about Care Point?_____

Financial Policy and Insurance Authorization/Office No Show and Cancellation Policy
I hereby authorize and direct the above named medical/dental practice to release to government agencies, insurance carriers or others who are financially liable for my medical/dental care all information to substantiate payment for such medical/dental care and to permit representatives thereof examine and make copies of all records relating to such care treatment and I hereby assign, transfer and set over to the above named medical/dental practice sufficient monies and/or benefits to which I am entitled from government agencies, insurance carriers or others who are financially liable for my medical/dental care to cover the costs of the care and treatment rendered to myself or my dependent in said practice.

I understand that I must show up for my appointments. A 15- minute grace period will be given at the provider discretion, otherwise I will be no-showed and/or rescheduled. If I no-show for more than two (2) appointments, my provider has the option to discharge me from the practice.

Patient or Guardian Signature:_____Date:_____

Authorization for Release of Medical Information

Please forward copies of requested records to:

Care Point Health & Wellness Center
2200 South Monroe Street
Tallahassee, FL 32301

O: (850) 354-8765
F: (850) 900-5941

Please forward copies of medical records from
(one form per provider/facility)

_____

_____

_____

I authorize Care Point Health & Wellness Center to search and secure any records on the Health Information Exchange Network (HIE) ☐ Yes ☐ No

Release the following:

_____Entire Health Record
_____Immunization Records Only
_____Specific Dates of Treatment: From:_____To_____

_____Other_____

I am requesting that this protected health information be released for the following reason: ("at the request of the individual" is all that is required if you do not desire to state a specific purpose.)

☐ This request is being made because I am transferring care to another provider or leaving the area.

☐ This authorization shall remain in effect until_____(up to 6 months) at which time this authorization expires.

☐ I also authorize for the release of information regarding assessment, diagnosis and treatment of alcohol and/or substance abuse.

☐ I also authorize for the release of information regarding diagnosis and/or treatment of AIDS or HIV.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to Care Point Health & Wellness Center at the above address.

I hereby authorize Care Point Health & Wellness Center to disclose my medical information as requested. Information used or disclosed by this authorization may be subject to subsequent disclosure by the recipient and no longer be protected by this rule.

Patient Name:_____Date of Birth:_____

Patient Signature:_____Date:_____

Legal Guardian:_____Relationship:_____

Legal Guardian Signature:_____Date:_____

Care Point Witness Signature:_____Date:_____

HIE Participation informed consent

This organization participates in a Health Information Exchange (HIE) to facilitate the care of our patients. Your records may be shared with your other providers that declare provider relationships with you via phone, fax, or HIE. You may decline to participate in HIE by going to https://secure.fl.hienetworks.com/PatientOptOut.aspx and following the directions.

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HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: *Relationship:*

_____ _____

Phone: _____

Health Information to be disclosed upon the request of the person named above: (Initial either A **or** B):

A. _____Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**

B. _____Disclose my health record, as above, **BUT do not disclose** the following (check as appropriate):

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify):

  _____
  _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

☐ Hard copy and/or verbal

This authorization shall be effective until (Check one):

☐ All past, present, and future periods, OR

☐ Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization Date of Birth

_____ _____
Signature of the Individual Giving this Authorization Date

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

• Obtain payment from third-party payers.

• Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy practices from time to time and that I may contact this organization at 2200 S. Monroe Street, Tallahassee, FL to obtain a current copy of the Notice of Private Practices.

Patient Name: _____

Signature: _____

Date: _____

Date of Birth:_____**Last Four SS#:**_____

Legal Guardian: _____

Relationship to Patient:_____