PATIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: ___ / ___ / _____ Age: _____

Sex: ___ Race: _____ Language: _____ Marital Status: _____ Occupation: _____
Parent/Guardian Name, if minor: _____ Relation: _____

Local Address: _____ City: _____ State: _____ Zip: _____
Permanent Address: _____ City: _____ State: _____ Zip: _____
Cell Phone: _____ Home Phone: _____ E-mail: _____
Emergency Contact: _____ Phone: _____ Relationship: _____
How did you hear about us? ☐ Google ☐ Facebook ☐ Insurance ☐ Patient _____ ☐ Other

Pharmacy: _____ Pharmacy Phone: _____ Pharmacy Address: _____

Insurance Information

Primary Carrier: _____ Policy #: _____ Group #: _____
Policy Holder: _____ Policy Holder Date of Birth: _____
Secondary Carrier: _____ Policy #: _____ Group #: _____
Policy Holder: _____ Policy Holder Date of Birth: _____

Guarantor/Person Responsible for Medical Expenses, if not patient

Name: _____ Date of Birth: _____ Phone: _____ Relation: _____
Address: _____ City: _____ State: _____ Zip: _____

Current Medications

Name of Medication	Dose & Frequency	Reason for Medication

Allergies: _____ ☐ **No Known Drug Allergies**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Giving Consent

Name: _____ DOB: _____

SECTION B: To the Patient - Please read the following statements carefully

Purpose of Consent. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide to sign the Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain. You may obtain a copy of our Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **Brittany Lewis**

Address: **6266 Lake Osprey Dr. Lakewood Ranch, FL 34240**

Telephone: **OFFICE #: 941-867-2560**

Fax: **OFFICE FAX #: 941-946-8750**

Website: https://www.suncoastfamilywellness.com/

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on the Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____ have had full opportunity to read and consider the contents of this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

Signature: _____ **Date**: _____

AUTHORIZATION/CONSENT FORM

A. ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION:

I authorize **Suncoast Family Wellness** to release to your health insurance company or its representatives any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical or Surgical care. I AUTHORIZE PHYSICIAN AND INSURANCE CLAIMS TO BE PAID DIRECTLY TO THE PRACTICE OR IT'S REPRESENTATIVE.

Please initial here _____ *

B. CONSENT TO TREAT:

I authorize Suncoast Family Wellness to take x-rays, or any other diagnostic aids deemed appropriate to make a thorough diagnosis. I authorize the providers to perform all recommended treatment mutually agreed upon. I also agree to the use of appropriate mediation and therapy indicated for such treatment.

Please initial here _____ *

C. TREATMENT OF MINORS: (Skip if not applicable)

I, as a parent/legal guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during such treatment, and waive any claim I may have resulting from failure to do so.

Please initial here _____ *

D. LIABILITY/ WAIVER AND RELEASE:

I hereby release, discharge, and acquit **Suncoast Family Wellness**, its agents, representatives, affiliates, employees, or of and from any and all liability claim, demand, damage, use of action, or loss of any kind arising out of or resulting from my refusal to accept, receive, or allow emergency and /or medical services, including but not limited to ambulance, EMT, or Physician service.

Please initial here _____*

E. FINANCIAL RESPONSIBILITY:

I understand fully that in the event my insurance company or financially responsible party does not pay for the services I or guarantees receive, I will be financially responsible for payment. I understand that it is my responsibility as the insured to ensure my plan is in-network with Suncoast Family Urgent Care & Wellness Center. I agree to pay all copayment and co-insurance at the time of the visit. I understand that it is my responsibility to advise your office of any changes associated with your insurance policy. For patients without health insurance, payment is REQUIRED at the time of your visit.

Please initial here _____ *

F. NOTICE OF PRIVACY:

I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES.

Please initial here _____ *

I, THE PATIENT/GUARANTOR/LEGAL GUARDIAN, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

*PATIENT/ GUARANTOR SIGNATURE x. _____ DATE: _____

*GUARDIAN SIGNATURE x_____ DATE: _____

If patient is under 18 years of age

Authorization to Discuss Medical Information

I hereby authorize **Suncoast Family Wellness and Urgent Care** to use and/or disclose the specific information described below, only for the purposes and/or parties listed below.

Description of the specific information to be discussed:

Appointment: Date & Time(s) _____ Diagnosis _____ Imaging/Lab Results _____ Medications _____

Summary of Medical Records Care Plan _____ Other (Specify):_____

Indicate Confidential Information:

Mental Health _____ HIV Information _____ Alcohol/Drug Information _____

Patient Name: _____

Date of Birth: _____

Information to be given to:

Name: _____

Relationship: _____

Address: _____

Phone/Fax: _____

This authorization shall remain in effect from the date signed below until (Please check one):

☐ NO EXPIRATION DATE ☐ _____ (Specify expiration date)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office.
- This authorization is giving **Suncoast Family Wellness** the right to discuss my medical information with the above mentioned.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.

Signature: _____ Date: _____

Signature of Patient's Authorized Representative: _____ Date: _____

ELECTRONIC COMMUNICATION CONSENT FORM

Texting Consent:
As part of our practice's communications with you, we can send you text messages directly to your phone.

☐ I **consent** and accept receiving **text messages**. I understand I can withdraw my consent at any time.

☐ I do not consent to receiving any text messages.

Patient Portal Consent:
As part of our practice's communications with you, we can send you messages directly to your patient portal.
Note: An email address must be provided to access the patient portal.

☐ I **consent** and accept receiving **patient portal messages**. I understand I can withdraw my consent at any time.

☐ I do not consent to receiving any patient portal messages.

Email Consent:
Due to security, details of one's case cannot be discussed via email. By signing, you are also aware that email is not a guaranteed or secure way of sending and receiving information and that you may not hold our clinic or your service provider responsible for any breach of confidentiality that results from the use of the email addresses listed below.

☐ I **consent** and accept the risk in receiving information via **email**. I understand I can withdraw my consent at any time.

☐ I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

I, the patient, understand that I should not use electronic communication in the event of an emergency, as our clinic cannot guarantee a rapid response via these modalities.

Print name of Patient: _____ Date: _____

Patient Signature: _____

No-Show and Late Cancellation Policy

We strive to provide exceptional medical care in a timely manner. Our staff understands your time is precious and that changes may occur with little notice. To efficiently serve all of our patients we require a 24-hour notice for all cancellations. This provides us enough time to offer your valuable appointment time to another patient. Late arrivals may be asked to reschedule.

Appointments cancelled with less than 24-hours notice may be charged a cancellation fee of $25.00.

Patients who "no-show" their appointment may be charged a fee of $25.00.

This fee is the patient's responsibility and is not covered by insurance.

Repeated missed appointments may result in restrictions on future scheduling.

As a courtesy to you, the first cancellation/no-show fee may be waived based on circumstances. It is our strong desire to create a lasting relationship built on mutual respect. We do everything we can to accommodate your schedule and we thank you in advance for your cooperation.

Patient Acknowledgment:
I understand and agree to the No-Show and Late Cancellation Policy.

Patient Name: _____
Signature: _____
Date: _____