Azalea Health
PATIENT REGISTRATION
All Information is Required and Confidential

PATIENT INFORMATION

Last Name: _____ First: _____ MI: ____ Nickname:_____
Birth Date: _____Social Security Number: _____ Sex: ❑ Male ❑ Female
Mailing Address: _____Apt#_____ 911 Address _____Apt#_____
City: _____State: _____ Zip: _____County:_____
Home Phone: _____Work Phone:_____ Cell Phone:_____
Marital Status: ❑ Single ❑ Married ❑ Other Employed: ❑ Yes ❑ No Employer/School: _____
Driver's License # and State: _____ **Email address:** _____

Primary Medical Insurance:_____

Name of Head of Household:_____ Date of Birth:_____ SS#_____
Phone # if different from above:_____ **Relationship:** _____

Alternate or Emergency Contact:_____ Phone: _____ Relationship: _____

***** THIS SECTION MUST BE COMPLETED FOR RESPONSIBLE PARTY OR IF PATIENT IS A MINOR *****

Last Name: _____First: _____Date of Birth:_____ SS#_____
Mailing Address: _____Apt# _____City: _____State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone:_____
Relationship to the Child: _____ Driver's License #: _____

Race: (**Please check one**)
❑Black/African American (B) ❑Hispanic/Black/African American (B) ❑White/Caucasian (W)
❑Hispanic/White/Caucasian (W) ❑Hispanic/White/Caucasian (W) ❑Pacific Islander (PI)
❑Hispanic/Pacific Islander (PI) ❑American Indian/Alaska Native(I) ❑Hispanic/American Indian/Alaska Native (I)
❑Asian (A) ❑Hispanic/Asian (A) ❑Native Hawaiian (NH) ❑Hispanic/Native Hawaiian (NH) ❑Multi Race (MR) ❑Hispanic/Multi Race (MR)
********** **Ethnicity Identity Only**: Hispanic/Latino ❑Yes ❑ No **********

***** This is strictly confidential information and is used solely for Azalea Health's benefit.*****
Are you a Veteran?: ❑Yes ❑ No **Has anyone in your family been a farm worker in the last 2 years?** ❑Yes ❑ No
Check What is Applicable: ❑ Migrant Worker ❑ Seasonal Worker Public Housing: ❑ Yes ❑ No
What is your living status? ❑ Doubling Up ❑Not Homeless ❑ Shelter ❑ Street ❑Transitional

CONSENT FOR TREATMENT: I authorize Azalea Health staff to provide medical and/or dental treatment including any necessary procedures required in the course of diagnosis and treatment.

Signature:_____ Date:_____

Witness:_____ Date:_____

INSURANCE ASSIGNMENT: I hereby assign to Azalea Health my right to the insurance benefits that may be payable for services provided, arising from any insurance policy, in my name, or in my behalf. I authorize payment of benefits directly to Azalea Health. I understand that this assignment of benefits does not relieve me from responsibility for the balance on my account for services which may not be covered by Insurance, Medicare or Medicaid.

Signature:_____ Date:_____

Witness:_____ Date:_____ AH Form #109 010113

AZALEA HEALTH
SLIDING FEE APPLICATION

Azalea Health is a non-profit organization that receives a defined amount of Federal funding to supplement the cost of providing Medical/Dental care to patients who are eligible to participate in the sliding fee scale program. Eligible patients will also qualify for reduced cost prescriptions. To determine your eligibility for this federally funded program, verification of your income is required. ***You must update this information at least annually to continue your participation in the program. This information is only used to calculate your discount and is kept confidential.***

Patient Name _____ **Date:** _____

I would like to apply for the Azalea Health Sliding Fee: ☐Yes ☐No

Household Size: # of Adults _____ # of Children _____ Total _____

A household constitutes any group of individuals, with or without children, living under the same roof that pool recourses for monthly expenses. Persons may or may not be related. Please List below.

1. _____ **3.** _____ **5.** _____

2. _____ **4.** _____ **6.** _____

Documentation Required for Sliding Fee:

a. **Pay Stubs (Household's pay stubs for most recent 4 weeks)**
b. **Employer Letter (If paid in Cash)**
c. **Unemployment Benefit Summary Letter**
d. **Copy of Tax Records, Bank Statements**
e. **Other (Veterans, Social Security, Pension Benefits, Child/Alimony, Workman's Comp)**
f. **No Income - Provide a Notarized letter from person you know (not related) verifying you have no income and stating your living arrangements (food/shelter)**
g. **Proof of Residency (utility bill, lease/mortgage, legal correspondence mailed to you in your name or your spouse's name)**
h. **Proof of Identity (Government Issue ID, Current DL, School ID, Birth Certificate)**

I certify that my total Household income is $ _____/monthly or $ _____/yearly

By signing this, I certify that all of the information is true. I understand that misrepresentation of income in order to participate in the sliding fee scale program is Federal Fraud. I understand that I am responsible for reporting if the number in my household or my income changes; I agree to report those changes to Azalea Health at the time of my next office visit. I understand and agree that I am responsible for payment of my portion of the charges after the sliding fee scale is applied.

Patient Signature Date

Office Use Only:

☐ Pay Stub ☐ Copy of Taxes ☐ Notarized Letter ☐ Proof of Residency ☐ Employer Letter
☐Medicaid Eligibility Letter ☐Other (Social Security/Pension ☐ Unemployment Benefit Letter
☐ Other Notarized Letters ☐ Child/Alimony ☐Workman's Comp ☐ Other Income ☐Bank Statements

Effective Date _____Renewal Date_____ Approved by_____ Date_____

Azalea Health
Designated Individuals Authorization Form

I wish to be contacted in the following manner (check all that apply)	
Home telephone _____ ❑ OK to leave message with detailed information. ❑ Leave message with call back number only.	Work telephone _____ ❑ OK to leave message with detailed information. ❑ Leave message with call back number only.
Written Communication ❑ OK to mail to my home address. ❑ OK to mail to this address:_____	

Communication with Family and Others Involved In Your Care

Please list any family members or others who may be involved in coordinating your care.
Also, please indicate what kind of information may be shared with each individual.

		Type of Information			
Name	Relationship to Patient	All	Appointment	Medical	Billing/Payment

I understand that I may cancel this designation at any time by signing the revocation section below. I understand that any cancellation can only apply to future disclosures and cannot cancel actions taken or disclosures made while the designation was in effect.

Patient Signature	Date:
Witness Signature	Date:

Revocation Section

I hereby cancel this authorization for designated individuals to have access to my protected health information.

Signature:_____ Date: _____

Place Patient ID label here

AZALEA HEALTH
MEDICAL HISTORY FORM

Patient Name: **DOB:**

Allergies: (medications, foods or plants)

MARK AN (X) If you HAD or HAVE at present	Yes		Yes		Yes		Yes
Heart problems or chest pain		Shortness of breath		Sickle cell disease		Enlarged glands or lymph nodes	
Fever/Chills		Chronic cough		Yellow jaundice		Limited movement	
Heart murmur		Tuberculosis (TB)		Blood transfusion		Ankles swell	
Rheumatic fever		Asthma		Drug addiction		Fainting or dizzy spells	
High blood pressure		Hay fever		More than 5 drinks per day		Tire easily	
Heart pacemaker		Sinus trouble		Hemophilia		WOMEN:	
Artificial heart valve		Use tobacco products		Stomach pain		Menarche	
Sleep on more than 2 pillows or sleep problems		Lung disease or frequent respiratory infections		Gained or lost more than 10 pounds in past year		Birth Control	
Thyroid disease		Smoker in house		Epilepsy or seizures		Anticipate becoming pregnant?	
Stroke		Vision problems		Nervousness/anxiety		Pregnant Now?	
Hepatitis/Liver disease		Hearing problems		Psychiatric treatment		Number of children?	
Artificial joint		Ear aches		Domestic Violence		Menstruation problems? Menopause ☐ Yes ☐ No Age_____	
Anemia		Lead poisoning		Excessive bleeding		DENTAL:	
Diabetes		Chemotherapy/Radiation		Special diet		Allergies to dental anesthetics	
Kidney trouble		Arthritis		Persistent diarrhea/constipation		Problems with extractions	
Problems with urination		Cortisone medicine		Nausea or vomiting		Missing teeth	
Ulcers		Glaucoma		Genital sores		Bleeding gums or frequent cavities	
Emphysema		HIV/AIDS		Sexually transmitted disease		Dental pain, cold sores	
Cancer or tumor		White or blue patches in mouth		Bad breath		Fluoride supplements	

List all Health Professionals you have visited outside of our clinic within the past 2 years and for what reason.

Have you had any surgeries? Yes/No If yes, please explain type of surgery and at what hospital or surgery center.

Please list all your medications (include non-prescription)

To the best of my knowledge all the answers are true and correct. If I ever have any change in my health I will inform my doctor.

Provider Signature **Date**

Patient Signature **Date**

Azalea Health

SOCIAL AND FAMILY HISTORY OF THE PATIENT INFORMATION

All the information that you provide in this questionnaire is strictly confidential and will become part of your medical record

¨ Male ¨ Female

¨Single ¨Married ¨Divorced ¨Separated ¨Widowed

Lives with: ¨Alone ¨Spouse ¨Parents ¨Children ¨Other: _____

Occupation:	Highest Level of Completed Education:

Number of Children? ¨Dependent ¨Independent

Do you smoke? ¨No ¨Yes, How Long? _____ How many? _____ Have you ever previously smoked, if yes, When did you quit?

Do you drink alcohol? ¨No ¨Yes, How often? How much? ¨Recreational Drugs? _____

If Diabetic, do you have annual exams? ¨No ¨Yes Last Appointment _____ By Whom? _____

Annual eye exams? ¨No ¨Yes Last Appointment _____ By Whom? _____

Annual Feet exam? ¨ No ¨Yes Last Appointment _____ By Whom? _____

DAILY ACTIVITY

¨ Walk ¨ Run ¨ Ride bicycle ¨ Swim ¨ Aerobics ¨ GYM

¨ Active ¨ Moderately Active ¨ Very Little or No Activity

DIET

¨No Restrictions ¨Low Fat ¨Low Salt ¨Diabetic Diet Calorie Intake _____

Other:_____

Childhood Illness

¨ Measles ¨ Mumps ¨ Rubella ¨ Chicken Pox ¨ Polo ¨ Rheumatic Fever

Are there smoke detectors in your home? ¨ No ¨ Yes

Fire arms in home? ¨ No ¨ Yes If yes, are safety measures taken? ¨ No ¨ Yes

Do you have a Family History of Cancer: ¨ Breast – relationship _____ ¨Colon – relationship _____

¨ Ovarian – relationship _____ ¨ Prostate– relationship _____ ¨ Other: _____– relationship _____

Do you have a Family History of: ¨ Diabetes– relationship _____ ¨ Heart Disease– relationship _____

¨ High Blood Pressure – relationship _____ ¨other? _____ – relationship _____

Add any pertinent personal, social or family history below:

_____

_____

_____

_____

_____

_____

_____

_____

Azalea Health
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this notice, please contact our

Corporate Compliance Officer
613 Saint Johns Ave Suite 304
Palatka, FL 32177
(386) 326-7336

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We maintain a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Azalea Health. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

Make sure that health information that identifies you is kept private. Give you notice of our legal duties and privacy practices with respect to health information about you; and follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose health information. Each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted disclose information will fall within one of the categories.

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices, at the hospital if you are hospitalized, or at another doctor's office, lab, pharmacy or other health care provider to whom we may refer you for consultation to take x-rays, to perform lab tests, to have prescriptions filled, or for other treatment purposes. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian at the hospital if you have diabetes so that we can arrange for the appropriate meals. We may also disclose health information about you to personnel assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

For Payment: We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. For example, we may need to give health information about your office visit so your health plan will pay us or reimburse you for the visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover treatment.

For Health Care Operations: We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our patients are.

Research: Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with patients' need for privacy of their health information. We will always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are.

As Required by Law: We will disclose health information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans: If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report birth or deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About a victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About criminal conduct at our facility; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Coroners, Health Examiners and Funeral Directors: We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release health information about you to authorized federal officials for intelligence, counterintelligence, or other national security activities authorized by law.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution or provide you with healthcare; (2) to protect the health and safety of yourself or others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding health information we obtain about you:

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records. This does not include psychotherapy notes. To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to our Corporate Compliance Officer. If you request a copy of the information, we may charge a fee for the costs associated with your request.

Right to Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend this information. To request an amendment, your request must be made in writing, submitted to our Corporate Compliance Officer. In addition, you must provide a reason that supports your request for an amendment.

We may deny your request for the amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us;
- Is not part of the health information kept by or for our organization;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures: You have the right to request an accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment and health care operations, as previously described.

To request this list of disclosures, you must submit your request in writing to our Corporate Compliance Officer. Your request must state a time period which may not be longer than six years and may not include dates before April 01, 2003. The first list you request within a 12 month period is free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost in advance. We will mail you a list of disclosures in paper format within 30 days of your request.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care, such as a family member or friend. For example, you could ask that we restrict a specified nurse from use of your information, or that we do not disclose information to your spouse about a surgery you had.

We are not required to agree to your request for restrictions if it is not possible for us to ensure our compliance or believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, make your request in writing to our Corporate Compliance Officer. In your request, you must tell us what information you want to limit and to whom you want the limits to apply; for example, use of any information by a specified nurse, or disclosure of specified surgery to your spouse.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box.

To request confidential communications, make your request in writing to our Corporate Compliance Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a paper copy of this Notice: You have the right to obtain a paper copy of this notice at any time. To obtain a copy, please request it from the front desk staff.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, the effective date of this Notice.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us contact the Corporate Compliance Officer. All complaints must be submitted in writing. ***You will not be penalized for filing a complaint.***

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

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

I understand that as part of my health care, original or maintaining paperwork, and/or electronic health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans of future care or treatment, serves as:

- A basis for planning my care and treatment,
- A means of communicating among the many health professionals who contribute to my care,
- A source of information for applying my diagnostic information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and,
- 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 a copy of Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing the consent,
- The right to inspect and copy health information used to make decisions regarding my care,
- The right to amend my health information if I feel it contains incomplete or incorrect information,
- The right o an accounting of disclosure of my health information,
- The right to request confidential communications regarding my health information.

I understand that it is not required to agree to the restrictions request, if it is not possible for us to ensure our compliance or you believe it will negatively impact the care we may provide you.

I understand and accept the terms of this consent.

Patient Signature:	Date:
Witness Signature:	Date: