UF | UNIVERSITY of FLORIDA
Archer Family Health Care
A Service of the College of Nursing

16939 SW 134th Ave
Archer FL 32618-5413
352-495-2550 Phone
352-495-3401 Fax

Dear New Patient,

Welcome! Thank you for choosing Archer Family Health Care, a health care service of the UF College of Nursing. Attached is the patient packet. We ask that you complete all pages thoroughly and bring it with you to your visit. If you take any prescribed or over-the-counter medication, please bring your bottle(s), even if empty, with you. You will need to arrive 30 minutes early to allow enough time to meet with the Financial Assistant Counselor prior to your appointment.

We are located at 16939 SW 134th Avenue in downtown Archer. If you are traveling on State Road 27/45 north bound turn left at 134th Ave; if you are traveling south bound turn right. Continue approximately 2/10th of a mile. We are located on the left side of 134th Ave.

We strive to see our patients on time and appreciate your promptness. If your wait is longer than 20 minutes, please notify the person at the front desk.
A 24 hour cancellation notice is required. However, if circumstances arise and you need to change your appointment time, please give as much notice as possible to allow someone else to be scheduled in the time reserved for you.

Please bring your photo identification and insurance information with you. We will bill your insurance company. However, you will be responsible for non-covered services, out-of-network services, deductibles, coinsurances, and/or co-payments.

If you are applying for the Reduced Payment Program, verification of your financial status and total household income is needed to determine your co-pay. If the required information is not provided, you will be charged the full fee for services rendered.

Payment is due at the time service is rendered. We accept cash, debit and credit cards.

You can visit our website at http://afhc.nursing.ufl.edu to learn more about Archer Family Health Care.

Thank you for choosing our health care team.

Meet Our Team:
ARNPs: Denise Schentrup, DNP, ARNP, Clinic Director; Ashley Kairalla MSN, ARNP; Danielle Dodd MSN,ARNP; Susan Shaffer, PhD, ARNP; Karen Rye, MSN, ARNP-MH; Stacia Hayes, MSN, ARNP; Lou Hillebrand, CMW
Consulting Physician David Feller, MD
Clinical Pharmacist James Taylor Pharm, D; Karen Whalen, Pharm, D, BCPS, CDE
Practice Manager Joan N. Walker, CMM, CPM

Clinical Support Staff
Chikako Alvarado, LPN
Sarai Torres, LPN

Administrative Staff
Phyllis Stephens, Financial Assistance Counselor
Dawn Alexander, CPB Clinical Service Representative II
Ana Ortiz, Clinical Service Representative I
Gillian Eagle, RN, CDC, Case Manager
Tom E. Metcalfe Jr., MBA Business System Builder

UF | Archer Family Health Care
College of Nursing
16939 SW 134th Ave Archer, FL 32618
Office (352) 495-2550 Fax: (352) 495-3401

PATIENT INFORMATION

Today's date:

Patient Name: | Date of Birth: PT ID:

Preferred Name/Nick Name:

Address: City: State: Zip: County:
Phone: Home: Cell Phone: Work:

Sex: | Social Security # | [ ] Veteran

Marital Status: [ ]Single [ ]Married [ ]Other

If Married, Spouses Name:
First Name:________________ Last:____________________ Birth Date:______________

Email: | Best way to contact: [ ] Home/Cell [ ] Work [ ] Email

Referred by: | Primary Care:

Primary language:

Race:

[ ] African American/Black [ ] Caucasian/White [ ] Asian [ ] American Indian/Alaskan Native
[ ] Native Hawaiian [ ] Other Pacific Islander [ ] More than One Race (choose both) [ ] Other ___________

Ethnicity:
[ ] Hispanic or Latino [ ] Non-Hispanic or Latino [ ] Other or Undetermined [ ] Patient Decline

Employment:
- [ ] Employed Full Time
- [ ] Employed Part Time
- [ ] Full Time Student
- [ ] Part- Time Student
- [ ] Unemployed
- [ ] Retired
- [ ] Disabled

Employer or School:
____
Address:
____
____
Phone:
____

Emergency Contact:

Phone: | Relationship:

Total number of Family Household Members: Insured or Uninsured

Household Income $ | Per [ ]Month [ ]Week [ ] Year | Source of Income

Primary Insurance Information

Insurance Company Name:

Insured Party Name: First Middle Last

Insured Party DOB: Insured ID: Other Insured ID:

Policy # Group # Group Name:

Secondary Insurance Information

Insurance Company Name:

Insured Party Name: First Middle Last

Insured Party DOB: Insured ID: Other Insured ID:

Policy # Group # Group Name:

________________________________, is Authorized to receive Protected Health Information in my absence or on my behalf. I understand this authorization will remain in effect for one (1) year or until I revoke it in writing (i.e., tell UF Archer Family Health Care to cancel it).

Patient/Patient Representative Signature:________________________________ Date: __________

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.)*: ☐ **M** ☐ **F**	**DOB:**
Marital status: ☐ **Single** ☐ **Partnered** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**	
Previous or referring doctor:	**Date of last physical exam:**

HAVE YOU BEEN TO THE EMERGENCY ROOM IN THE PAST YEAR? ☐**NO** ☐**YES FOR WHAT REASON?**

PERSONAL HEALTH HISTORY

Immunizations and dates:	☐ **Tetanus**	☐ **Pneumonia**
	☐ **Hepatitis**	☐ **Influenza**

List any medical problems/testing that other doctors have diagnosed/completed

☐ **Allergies (Seasonal)** ☐ **Abnormal pap smear** ☐ **ADHD** ☐ **Anxiety** ☐ **Arthritis** ☐ **Asthma** ☐ **Bipolar disorder** ☐ **COPD**

☐ **Cancer Type**________________ ☐ **Chicken Pox** ☐ **Chronic back pain** ☐ **Depression** ☐ **Diabetes** ☐ **Diverticulitis** ☐ **Fibromyalgia**

☐ **GERD** ☐ **Hearing problems** ☐ **Heart Disease** ☐ **Hepatitis** ☐ **Herpes** ☐ **High blood pressure** ☐ **High Cholesterol** ☐ **Migraines**

☐ **Miscarriages** ☐ **Seizures** ☐ **Stroke** ☐ **Thyroid problems** ☐ **Tuberculosis** ☐ **Vision problems** ☐ **Other**____________________

Surgeries

Year	Reason	Hospital

Other Hospitalizations

Year	Reason	Hospital

The Foundation for The Gator Nation
An Equal Opportunity Institution

Name:		DOB:	
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers			
Name the Drug	Strength/frequency	Name of Drug	Strength/frequency
1.		9.	
2.		10.	
3.		11.	
4.		12.	
5.		13.	
6.		14.	
7.		15.	
8.		16.	

Allergies to medications (name the drug and reaction you had)	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Alcohol	Do you drink alcohol?		☐ Yes	☐ No
	If yes, what kind?			
	How many drinks per week?			
Tobacco	Do you use tobacco?		☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or year quit		
Drugs	Do you currently use recreational or street drugs?		☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?		☐ Yes	☐ No
Safety	Have you now, or in the past, felt physically, emotionally or verbally abused or been hit, kicked, punched or slapped?		☐ Yes	☐ No
Sex	Are you sexually active?		☐ Yes	☐ No
	If yes, gender of partner?	☐ Male	☐ Female	☐ Both
	Is there any chance you may be pregnant?		☐ Yes	☐ No

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

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Archer Family Health Care
UNIVERSITY *of* FLORIDA

CONSENT AND AUTHORIZATION

MRN: ______________________ **PATIENT NAME:** ______________________________ **VISIT DATE:** ______________

SECTION A: NOTICE OF LIMITED LIABILITY

I, ON BEHALF OF MY SELF, MY CHILD, AND/OR MY WARD, HEREBY ACKNOWLEDGE I HAVE BEEN INFORMED THAT: Health care and treatment that I/ we receive at Archer Family Health Care will be provided by University of Florida employees and/or agents, including but not limited to nurse practitioners, nurse-midwives, nurses and students, clinical pharmacists, and physicians, ("health care providers"). I understand these health care providers are under the exclusive supervision and control of the University of Florida Board of Trustees and liability for their acts or omissions is limited to $100,000 per claim or judgment by any one person and to $200, 0 00 for all claims or judgments arising out of the same incident or occurrence (see Florida Statues 768.28).

I further acknowledge that University of Florida health care providers are neither the employees nor agents of Shands Teaching Hospital and Clinics, Inc.

Patient/Guardian ______________________________ Date ___________ Witness ______________________

SECTION B: TREATMENT AUTHORIZATION, ASSIGNMENTS OF PROCEEDS, AUTHORIZATION TO RELEASE INFORMATION AND GUARANTOR AGREEMENT

I. Authorization for Routine Diagnostic Procedures and Medical Treatment – I hereby consent to such diagnostic procedures, hospital care, and medical treatment which in the judgment of my health care provider may be considered necessary or advisable while a patient at Archer Family Health Care. I recognize that Archer Family Health Care providers are employees of a health care teaching and research institution and that my treatment and care will be observed and in some instances aided by students under appropriate supervision. I consent to Archer Family Health Care taking photographs of me in the course of and related to my treatment and to their use of such photographs and my medical data for educational purposes. I hereby authorize Archer Family Health Care to retain, preserve and use for scientific, educational or research purposes, or dispose of as they might deem fit, any specimens or tissues taken from my body during hospital or clinic visits.

II. Assignment of Benefits – I hereby assign to Archer Family Health Care payment from all third party payors* with whom I have coverage or from whom benefits are or may become payable to me, for the charges of hospital and health care services I receive for, related to, or connected with this admission or treatment (past, present, or future). I agree to be personally responsible for payment of any hospital or health care services that are not covered by my third party payors*, including, but not limited to, non-covered or out-of-network services, deductibles, co-insurances, and/or co-payments.

III. Release of Medical Information by Archer Family Health Care – By signing in the space below as Patient/Guardian, I hereby authorize Archer Family Health Care providers providing services during my outpatient clinical care, to release information from and/or copies of my medical records (including information relating to psychiatric and/or psychological care, alcohol and/or substance abuse, and HIV tests), and other information as may be required for my medical care and to secure payment for charges incurred by me or on my behalf, to: any University of Florida facility or affiliated provider, the Tumor Registry, my health care provider, referring provider, the Guarantor on my accounts, insurance companies for which I have assigned benefits for my treatment and care, or to any sponsors that Archer Family Health Care may later obtain to contribute payment for my treatment and care. I also authorize release of any information to any and all regulatory and/or accrediting organizations as necessary to maintain licensure and accredited status. In addition, I authorize release of any information to county, state or federal public health agencies, as required by law. I further authorize the Department of Children and Family Services and/or the Social Security Administration to release any confidential case information to my application for government assistance, which is requested by Archer Family Health Care.

IV. Guarantor Agreement- By signing in the space below as Patient/Guardian or Guarantor, or as Patient's/Guardian's Spouse or Guarantor's Spouse, I hereby agree that all charges connected with the treatment, not covered by any insurance, program, sponsorship or other third party coverage I may have, are due and payable by me at the time of the visit or discontinuation of treatment. If the insurance information I have provided is not active at the time of service or if the services provided are not covered by my insurance company, I will be responsible for any balance due at the time of service. The charges I agree to pay are those listed in the current Fee Schedule, which is available for inspection upon request. I hereby acknowledge that, unless Archer Family Health Care and my insurance company or third party carrier have agreed that I will not be billed, if Archer Family Health Care has agreed to bill my insurance or other third party carrier it has agreed to do so as a courtesy and that Archer Family Health Care has the right to demand payment in full from me at any time prior to full payment from any insurance carrier. If an overdue account is referred by collections, I agree to pay the attorney's fees, court costs and/or collection agency fees associated with the collection process. I specifically waive any exemption of wages from garnishment, which might be available by law, and agree that my wages can be garnished in the event a Judgment is entered against me for collection of the outpatient clinic charges I have agreed to pay.

V. Lien on Third Party Liability Proceeds – If any admission or treatment is due to an accident or injury, Archer Family Health Care shall have a lien upon the proceeds of any cause of action, suit, claim, counterclaim, or demand accruing to me or my legal representative as a result of such accident or injury, in order to recover payment for all charges of hospital and health care services I receive for, related to, or connected with such accident or injury (past, present, or future), effective as of the date treatment was first provided. The foregoing shall be sufficient notice to me of the existence of a lien, which shall be effective whether or not it is filed in the public records. The foregoing is in addition to any lien to which Archer Family Health Care may be entitled by law.

VI. Agreement to Pay for Professional Component and Other Pathology Services – When a specimen of my blood, urine, stool, or similar materials is tested, the testing will be performed under the supervision of the pathologist who directs the laboratory. The pathologist may not perform the test or personally review its results. However, the pathologist is responsible for supervising the laboratory to assure that the results of all my tests are clinically reliable and are reported to my health care provider in a timely manner. I will receive a bill from the pathologist for these supervisory services for each test even if the pathologist did not personally perform the test or review its results. By signing this agreement, I agree to be responsible for the pathologist's bill to the extent that my insurer or managed care plan does not pay for it.

*Third party payors include, but are not limited to, coverage available from: Medicare, Medicaid, or governmental programs; health, accident, automobile, or other insurance; worker's compensation; HMO (commercial, Medicaid, Medicare); self-insured employers; and any sponsors who may contribute payment for services.

Patient/Guardian: ______________________________ Patient's/Guardian's Spouse: ______________________________

Insured ______________________________ (If other than patient) Insured ______________________________ (If other than patient)

Guarantor ______________________________ (If other than patient/guardian) Guarantor's Spouse ______________________________ (If other than patient's/guardian's spouse)

Witness ______________________________ Date ______________________________

COPIES OF THIS STATEMENT SHALL BE AS VALID AS THE ORIGINAL/ORIGINAL SIGNATURES ON FILE WITH ARCHER FAMILY HEALTH CARE

11/20/07

WHITE – PATIENT YELLOW – ARCHER FAMILY HEALTHCARE

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16939 SW 134th Ave
Archer, FL 32618
TEL (352) 495-2550 FAX (352) 495-3401

CONSENT TO OBTAIN MEDICATION HISTORY

Patient ID: __________

As a user of an electronic medical record, your Archer provider would like to include your medication history in your record. A medication history is a list of prescription medicines that we or other doctors have prescribed for you. This list is collected from several sources, including your pharmacy and your health insurance.

An accurate medication history is very important to help us treat you and to avoid potentially dangerous drug interactions. By signing this consent form you give us permission to collect, and give your pharmacy and your health insurance permission to give us information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medication to treat AIDS/HIV and medicines used to treat mental conditions, such as depression. This information will become part of your electronic medical record, should your provider feel it is important to your medical care.

This medication history is a useful guide, but it may not be complete. Some pharmacies do not make drug history available to us, and the drug history might not include over the counter medicines, supplements, or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to tell us about any errors in your medication history.

____ **I give permission for Archer Family Health Care to obtain my medication history from my pharmacy, my health insurance and my other healthcare provider.**

_____ **I DO NOT give permission for Archer Family Health Care to obtain my medication history from my pharmacy, my health insurance nor my other healthcare providers.**

Patient's Name ________________________________ Date of Birth ______________________

____ ________________________
Signature of Patient or Guardian Relationship to Patient

____
Employee Witness to Signature

____
Today's Date

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Patient Responsibility Policy

Proof of Income

1. Uninsured patients, who wish to be considered for care at a reduced cost, must provide proof of total household income each year. If proof of income is not provided on the first visit, the patient will be reminded by the Office Staff to bring this to the next visit. If proof is not provided at the time of the second visit future appointments will not be scheduled until such proof is submitted to the practice. As a reminder that proof of income is still needed, the Office Manager will send a letter to the patient requesting such information. If information is still not provided, urgent care will be provided for a period of 30 days and the patient will receive a letter of discharge fro the practice.

2. **Payment is Due at time Services are Rendered**
   Per the contract agreement between patients and insurance carriers, co-pays, deductible and any non-covered services are due at the time services are rendered. If a patient does not have health insurance, the quoted fee provided by the Office Staff is due at the time of service as well. We accept personal checks or cash.

3. **Payment Arrangement for Balance Due**
   If a patient wishes to establish a payment plan instead of paying in full for services rendered, the patient must request to speak with the Office Manager. The Office Manager will determine an appropriate payment plan based upon the patients income. The Patient and the Office Manager will agree upon the payment amount and date the payment is due in accordance with the payment plan or payments each month. It is the patient's responsibility to make contact with the Office Manager to discuss any unforeseen situations that might prevent timely payments.

   The Office Manager will contact patients who have past due balances by the 20th of each month as a reminder of the past due amount. If after 3 consecutive months there is no payment activity from the patient, the patient will be notified that Archer Family Health Care will provide only urgent care for a period of 30 days until the patient meets with the Office Manager to establish a new payment plan.

4. **Appointment Cancellations**
   Cancellation of an appointment or rescheduling of an appointment requires at least 24-hours notice.

5. **No Show**

A "no show" occurs when a patient fails to cancel or reschedule an appointment with at least 24-hours notice. If a patient accumulates 3 "no shows" the patient will receive a letter of discharge from the practice, which dismisses you from the practice for a period of one year. If at the end of one year the patient desires to come back to the practice the patient will be accepted as a new patient.

If a patient fails to cancel or reschedule two appointments with proper notice, a letter will be sent explaining how requests for future appointments will be handled.

6. **Adherence to Treatment**

Health Care is a partnership between the Patient and Healthcare Provider. It is the Provider's responsibility to discuss options for care and to recommend preferred plan of care to each patient. It is the patients' responsibility to adhere to the agreed upon plan of care. If a patient does not adhere to the plan of care after discussion with the provider, the provider may discharge the patient from the practice.

I have read the above Patient Responsibilities and agree to abide to the terms

________________________________ ________________

Patient or Guardians Signature Date

________________________________ ________________

Name DOB

Archer Family Health Care
A Service of the College of Nursing

16939 SW 134 Ave
Archer FL 32615
Phone: 352-495-2550
Fax: 352-495-3401

2016-17 APPLICATION FOR REDUCED COPAYMENT HEALTH CARE

Based on the information you provided, it appears that you may qualify for reduced co-payment. Please fill out the following form completely and honestly. List all income from all sources including Self-employment, Contributions from friends/relatives, Social Security Benefits, Pensions, Interest, Dividends, Child Support, Veterans Benefits, Unemployment/Workers' Compensation Rail Road Retirement, Annuities/Rent, Food Stamps and any other government assistance.

NAME: ________________________________ SOCIAL SECURITY #______-____-______ DATE OF BIRTH____________

**************************HOUSEHOLD MEMEBERS*************************

List yourself and all other household members and your relation to them. List the total monthly income for each family member. If a member has no incomes list the reason. Indicate if a member has Medicaid or Food Stamps. All patients applying for free or reduced services should apply for Medicaid and Food Stamps. If a member does not have Medicaid or Food Stamps state the reason for denial.

Member Name	Relation to You	Date of Birth	Monthly Income and Source	Medicaid or Food Stamps

Rights and Responsibilities for Financially Assisted Health Care

Archer Family Health Care provides medical care at reduced charges. The charges are based on income and asset information. Services will be provided at a $10.00 charge to individuals at or below the Federal Poverty guidelines and reduced fees will apply up to 200% of the Poverty guideline.

I am applying for reduced co-payment for my medical care to be received at Archer Family Health Care. I understand that Reduced co-payment services do not apply to outside laboratories or referrals for services performed outside of Archer Family Health Care. I understand that I have to give true and complete information on this form under penalty of perjury and can be prosecuted if I lie or hide information.

I agree that Archer Family Health Care and University of Florida, College of Nursing may verify the information I give on this form. I agree that they may contact my present or past employers if it relates to my eligibility. I agree that they may get information that affects my eligibility from any records or sources including information exchanges with other agencies.

I agree to notify Archer Family Health Care of any change in my situation immediately.

I have read and kept a copy of my Rights and Responsibilities. I declare the information provided on the other side of this form is true to the best of my knowledge. If false information is reported on this application you will be discharged from Archer Family Health Care.

Signature of Applicant/Guardian ______________________ Date ______________________

Witness ______________________ Date ______________________

11/10/16jnw

COLLECTION AND USE OF SOCIAL SECURITY NUMBERS AT THE UNIVERSITY OF FLORIDA

ORGANIZATION	PURPOSE	STATUATORY AUTHORITY	MANDATED, AUTHORIZED OR BUSINESS IMPERATIVE
Academic Technologies	State contractual obligation	6C1-3.020	Business imperative
Admissions	Student record management	Sec. 119.071(5)(a)(2)(a)(II), Fla. Stat.	Authorized
Baby Gators Child Development	DOH CCFP reimbursement	Sec. 383.011, Fla. Stat.	Authorized
Bridges	Identity Management (UF ID)	6C1-2.0031	Business imperative
College of Dentistry	Tax reporting	Sec. 6109, I.R.C.	Mandated
College of Medicine	Tax reporting	Sec. 6109, I.R.C.	Mandated
College of Nursing	Tax reporting; licensure	Sec. 6109, I.R.C.	Mandated; Authorized
College of Nursing Archer Clinic	Patient registration; health insurance claims or verification	6C1-1.300	Business imperative
College of Pharmacy	Tax reporting; student applications; education certifications	Sec. 6109, I.R.C.; Rule 64B16-26.203 & 2032, F.A.C.	Mandated; Business imperative
College of Public Health & Health Professions	Tax reporting	Sec. 6109, I.R.C.	Mandated
College of Veterinary Medicine	Tax reporting	Sec. 6109, I.R.C.	Mandated
Continuing Education	Licensure; identity management; student record management	Sec. 119.071(5)(a)(2)(a)(II), Fla. Stat.	Authorized
Faculty Practice Assoc (Dental Clinics)	Tax reporting; patient registration & health insurance verification	Sec. 6109, I.R.C.; 6C1-1.300	Mandated; Business imperative
Health Science Center Contracts	Contract services & management		Business imperative
Housing and Residence Education	Florida Prepaid Housing Program Reimbursement	Section 1009.98, Fla. Stat.	Authorized
Human Resource Services	Tax reporting; benefits eligibility	Sec. 6109, I.R.C.; 6C1-1.200	Mandated; Business imperative
IFAS Extension, 4-H Programs	FDLE & Background Checks	6C1-6.013; 6C1-3.0031	Business imperative
Psychology Clinic	Patient registration; health insurance verification; SSDI benefits	Sec. 119.071(5)(a)(2)(a)(II), Fla. Stat.	Authorized
Purchasing and Disbursements	Tax reporting; contracts & purchases	26 U.S.C. 6041.; 6C1-3.020	Mandated; Business imperative
Registrar	Student record management & VA benefits	Sec. 119.071(5)(a)(2)(a)(II), Fla. Stat.	Authorized
Reitz Union	Tax reporting	Sec. 6109, I.R.C.	Mandated
Research (Sponsored Research & General Clinical Research Ctr)	Tax reporting	Sec. 6109, I.R.C.	Mandated
Research Affairs & Compliance (RAC)	Tax reporting	Sec. 6109, I.R.C.	Mandated
Speech & Hearing Clinics	Patient registration; health insurance verification	Sec. 119.071(5)(a)(2)(a)(II), Fla. Stat.	Authorized
Student Financial Affairs	Financial aid programs	PL 110-315, Sec. 483	Authorized
Student Health Care Center	Health insurance verification	Sec. 119.071(5)(a)(2)(a)(II), Fla. Stat.	Authorized
Study Abroad Services (UF International Center)	Florida Prepaid Tuition Reimbursement	Section 1009.98, Fla. Stat.	Authorized
UF Physicians (Medical Clinics)	Tax reporting; health insurance	Sec. 6109, I.R.C.; 6C1-1.300	Mandated; Business imperative
UF Proton Therapy Institute	Tax reporting; health insurance verification	Sec. 6109, I.R.C.; 6C1-1.300	Mandated; Business imperative
UF Jacksonville Healthcare (Medical Clinics)	Tax reporting; health insurance verification	Sec. 6109, I.R.C.; 6C1-1.300	Mandated; Business imperative
University Financial Services	Tax reporting; financial aid; collections	Sec. 6109, I.R.C.; 6C1-3.042; Sec. 1010.03, Fla. Stat.	Mandated; Authorized
Veterinary Medical Center	Promissory notes/credit applications	15 U.S.C. Sec. 1681 et seq.	Authorized

Name

Date

DOB

This is the template for Archer Family Health Care

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COLLECTION AND USE OF SOCIAL SECURITY NUMBER

Your Social Security Number has been collected. It is imperative for the performance of this department's legal duties and responsibilities.

If you have questions about the collection and use of Social Security Numbers, please visit: http://privacy.ufl.edu/SSNPrivacy.html

UF | UNIVERSITY of FLORIDA

UFHealth
UNIVERSITY OF FLORIDA HEALTH

ACKNOWLEDGEMENT of Receipt

MRN: ___________ PATIENT NAME: ____________________________ VISIT DATE: ___________

I have been provided a copy of the Joint Notice of Privacy Practices for the University of Florida and UF Health Shands. I understand that I may ask questions about this Notice at any time.

Patient Signature: ____________________________________ Date: ______________________

If not signed by the patient, please indicate relationship:

Legal Representative Signature: __________________________________ Date: ______________

Relationship to Patient: ______________________________

***For Office Use Only*:**

Signed form received by: ______________________________________
Print Name

____
Print Facility Name

☐ Declined to Sign Acknowledgment

Efforts to obtain signature: ____

____

Reasons for refusal:

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UF | UNIVERSITY of FLORIDA

AUTHORIZATION to Use or Disclose Protected Health Information (PHI)

<table>
<tr><td>Patient's Name</td><td>Date of Birth</td><td rowspan="2">Verification of Identity (Driver's License, ID Card, Passport, etc.)</td></tr>
<tr><td>Patient's Address</td><td>Medical Record Number</td></tr>
</table>

** Complete the following only if the person authorizing the use or disclosure is not the patient:

Representative's Name	Relationship to Patient	Legal Authority
Representative's Address	Verification of Identity	Verification of Authority

By signing this form, I authorize the following:

<table>
<tr><td colspan="2">Disclosure of the patient's PHI <u>from</u>:</td><td colspan="2">Disclosure of the patient's PHI <u>to</u>:</td></tr>
<tr><td colspan="2">Person, class of persons, or organization</td><td colspan="2">Person, class of persons, or organization
Archer Family Health Care</td></tr>
<tr><td colspan="2">Address</td><td colspan="2">Address
16939 SW 134th Ave</td></tr>
<tr><td colspan="2"></td><td colspan="2">Archer, FL 32618-5413</td></tr>
<tr><td>Attn:
Medical Records</td><td>Phone
Fax</td><td>Phone
352-495-2550</td><td>Fax
352-495-3401</td></tr>
<tr><td colspan="4">The following protected health information may be disclosed:
Last 6 office visits, Lab results, Current Medication List, Radiology Reports</td></tr>
<tr><td colspan="4">I further authorize the disclosure of the following information which may be included in the protected health information listed above. (Check all that are approved.)</td></tr>
<tr><td>Mental Health</td><td>Substance Abuse</td><td>HIV/AIDS</td><td>Records created by non-UF/Shands providers</td></tr>
<tr><td colspan="4">The purpose of the disclosure is: Continuation of Care</td></tr>
</table>

I understand that, by federal law, the University of Florida may not use or disclose protected health information without authorization except as provided in the University's Notice of Privacy Practices. By signing this Authorization, I am giving permission for the uses and disclosures of the described protected health information. I hereby release the University of Florida and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that I have the right to revoke this Authorization at any time, if I do so in writing, and address it to the person or institution named above. I understand that the revocation will not apply to any actions already taken as a result of this authorization.

I understand that I may refuse to sign this Authorization, and that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

I understand that information disclosed pursuant to this Authorization may no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

I understand that I may be charged a fee of up to $1.00 per page (plus applicable tax and handling) for every page copied and that this fee is within the limits allowed by Florida law.

<table>
<tr><td>This authorization expires automatically one (1) year from the date signed, if no other date or event is specified.</td><td>Expiration Date or Event</td></tr>
<tr><td>This authorization may be used to disclose protected health information of the same type described above, which may be created in the future, until the expiration date.</td><td>YES NO</td></tr>
<tr><td colspan="2">I have read and understand the information in this authorization form.</td></tr>
<tr><td>Signature of Patient or Legal Representative:</td><td>Date</td></tr>
</table>

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Health Care Advance Directives

The Patient's Right to Decide

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment.

When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. To make sure that an incapacitated person's decisions about health care will still be respected, the Florida legislature enacted legislation pertaining to health care advance directives (Chapter 765, Florida Statutes). The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions; and/or to indicate the desire to make an anatomical donation after death.

By law hospitals, nursing homes, home health agencies, hospices, and health maintenance organizations (HMOs) are required to provide their patients with written information, such as this pamphlet, concerning health care advance directives. The state rules that require this include 58A-2.0232, 59A-3.254, 59A-4.106, 59A-8.0245, and 59A-12.013, Florida Administrative Code.

Questions About Health Care Advance Directives

What is an advance directive?
It is a written or oral statement about how you want medical decisions made should you not be able to make them yourself and/or it can express your wish to make an anatomical donation after death. Some people make advance directives when they are diagnosed with a life-threatening illness. Others put their wishes into writing while they are healthy, often as part of their estate planning.

Three types of advance directives are:

- A Living Will
- A Health Care Surrogate Designation
- An Anatomical Donation

You might choose to complete one, two, or all three of these forms. This pamphlet provides information to help you decide what will best serve your needs.

What is a living will?
It is a written or oral statement of the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living. You may wish to speak to your health care provider or attorney to be certain you have completed the living will in a way that your wishes will be understood.

What is a health care surrogate designation?
It is a document naming another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will. You can also designate an alternate surrogate.

Which is best?
Depending on your individual needs you may wish to complete any one or a combination of the three types of advance directives.

What is an anatomical donation?
It is a document that indicates your wish to donate, at death, all or part of your body. This can be an organ and tissue donation to persons in need, or donation of your body for training of health care workers. You can indicate your choice to be an organ donor by designating it on your driver's license or state identification card (at your nearest driver's license office), signing a uniform donor form (seen elsewhere in this pamphlet), or expressing your wish in a living will.

Am I required to have an advance directive under Florida law?
No, there is no legal requirement to complete an advance directive. However, if you have not made an advance directive, decisions about your health care or an anatomical donation may be made for you by a court-appointed guardian, your wife or husband, your adult child, your parent, your adult sibling, an adult relative, or a close friend.

The person making decisions for you may or may not be aware of your wishes. When you make an advance directive, and discuss it with the significant people in your life, it will better assure that your wishes will be carried out the way you want.

Must an attorney prepare the advance directive?
No, the procedures are simple and do not require an attorney, though you may choose to consult one. However, an advance directive, whether it is a written document or an oral statement, needs to be witnessed by two individuals. At least one of the witnesses cannot be a spouse or a blood relative.

Where can I find advance directive forms?
Florida law provides a sample of each of the following forms: a living will, a health care surrogate, and an anatomical donation. Elsewhere in this pamphlet we have included sample forms as well as resources where you can find more information and other types of advance directive forms.

Can I change my mind after I write an advance directive?
Yes, you may change or cancel an advance directive at any time. Any changes should be written, signed and dated. However, you can also change an advance directive by oral statement; physical destruction of the advance directive; or by writing a new advance directive.

If your driver's license or state identification card indicates you are an organ donor, but you no longer want this designation, contact the nearest driver's license office to cancel the donor designation and a new license or card will be issued to you.

What if I have filled out an advance directive in another state and need treatment in Florida?
An advance directive completed in another state, as described in that state's law, can be honored in Florida.

What should I do with my advance directive if I choose to have one?

- If you designate a health care surrogate and an alternate surrogate be sure to ask them if they agree to take this responsibility, discuss how you would like matters handled, and give them a copy of the document.
- Make sure that your health care provider, attorney, and the significant persons in your life know that you have an advance directive and where it is located. You also may want to give them a copy.
- Set up a file where you can keep a copy of your advance directive (and other important paperwork). Some people keep original papers in a bank safety deposit box. If you do, you may want to keep copies at your house or information concerning the location of your safety deposit box.
- Keep a card or note in your purse or wallet that states that you have an advance directive and where it is located.
- If you change your advance directive, make sure your health care provider, attorney and the significant persons in your life have the latest copy.

If you have questions about your advance directive you may want to discuss these with your health care provider, attorney, or the significant persons in your life.

More Information On Health Care Advance Directives

Before making a decision about advance directives you might want to consider additional options and other sources of information, including the following:

- As an alternative to a health care surrogate, or in addition to, you might want to designate a durable power of attorney. Through a written document you can name another person to act on your behalf. It is similar to a health care surrogate, but the person can be designated to perform a variety of activities (financial, legal, medical, etc.). You can consult an attorney for further information or read Chapter 709, Florida Statutes.

  If you choose someone as your durable power of attorney be sure to ask the person if he or she will agree to take this responsibility, discuss how you would like matters handled, and give the person a copy of the document.

- If you are terminally ill (or if you have a loved one who is in a persistent vegetative state) you may want to consider having a pre-hospital Do Not Resuscitate Order (DNRO). A DNRO identifies people who do not wish to be resuscitated from respiratory or cardiac arrest. The pre-hospital DNRO is a specific yellow form available from the Florida Department of Health (DOH). Your attorney, health care provider, or an ambulance service may also have copies available for your use. You, or your legal representative, and your physician sign the DNRO form. More information is available on the DOH website, www.doh.state.fl.us or www.MyFlorida.com (type DNRO in these website search engines) or call (850) 245-4440.

  When you are admitted to a hospital the pre-hospital DNRO may be used during your hospital stay or the hospital may have its own form and procedure for documenting a Do Not Resuscitate Order.

- If a person chooses to donate, after death, his or her body for medical training and research the donation will be coordinated by the Anatomical Board of the State of Florida. You, or your survivors, must arrange with a local funeral home, and pay, for a preliminary embalming and transportation of the body to the Anatomical Board located in Gainesville, Florida. After being used for medical education or research, the body will ordinarily be cremated. The cremains will be returned to the loved ones, if requested at the time of donation, or the Anatomical Board will spread

the cremains over the Gulf of Mexico. For further information contact the Anatomical Board of the State of Florida at (800) 628-2594 or www.med.ufl.edu/anatbd.

- If you would like to learn more on organ and tissue donation, please visit the Joshua Abbott Organ and Tissue Donor Registry at www.DonateLifeFlorida.org where you can become organ, tissue and eye donors online. If you have further questions about organ and tissue donation you may want to talk to your health care provider.

- Various organizations also make advance directive forms available. One such document is "Five Wishes" that includes a living will and a health care surrogate designation. "Five Wishes" gives you the opportunity to specify if you want tube feeding, assistance with breathing, pain medication, and other details that might bring you comfort such as what kind of music you might like to hear, among other things. You can find out more at:

  Aging with Dignity
  www.AgingWithDignity.org
  (888) 594-7437

  Other resources include:

  American Association of Retired Persons (AARP)
  www.aarp.org
  (Type "advance directives" in the website's search engine)

  Your local hospital, nursing home, hospice, home health agency, and your attorney or health care provider may be able to assist you with forms or further information.

  Brochure: End of Life Issues
  www.FloridaHealthFinder.gov
  (888) 419-3456

Living Will

Declaration made this _____ day of ________________, 2____, I, ___________________________, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and

_____(initial) I have a terminal condition,
or _____(initial) I have an end-stage condition,
or _____(initial) I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I do ___, I do not ___ desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name ____
Street Address ____
City ______________________ State _____________ Phone ___________

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional): ____
____
____
____
____

(Signed) ____

Witness ______________________________
Street Address _________________________
City _____________________ State _______
Phone _________________

Witness ______________________________
Street Address _________________________
City _____________________ State _______
Phone _________________

At least one witness must not be a husband or wife or a blood relative of the principal.

Definitions for terms on the Living Will form:

"End-stage condition" means an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.

"Persistent vegetative state" means a permanent and irreversible condition of unconsciousness in which there is: The absence of voluntary action or cognitive behavior of any kind and an inability to communicate or interact purposefully with the environment.

"Terminal condition" means a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.

These definitions come from section 765.101 of the Florida Statues. The Statutes can be found in your local library or online at www.leg.state.fl.us.

Designation of Health Care Surrogate

Name: ____

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name ____
Street Address ____
City ____________________ State ________ Phone __________
Phone: ____________

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name ____
Street Address ____
City ____________________ State ________ Phone __________

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.
Additional instructions (optional):

____
____
____
____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name ____
Name ____

Signed ____

Date ____________________

Witnesses 1. ________________________________

2. ________________________________

At least one witness must not be a husband or wife or a blood relative of the principal.

Uniform Donor Form

The undersigned hereby makes this anatomical gift, if medically acceptable, to take effect on death. The words and marks below indicate my desires:

I give:

(a) _____ any needed organs or parts

(b) _____ only the following organs or parts for the purpose of transplantation, therapy, medical research, or education:

____

____

____

(c) _____ my body for anatomical study if needed. Limitations or special wishes, if any:

____

____

____

Signed by the donor and the following witnesses in the presence of each other:

Donor's Signature ___________________________________ Donor's Date of Birth _____________

Date Signed ______________ City and State ____

Witness _____________________________ Witness _____________________________
Street Address ________________________ Street Address ________________________
City _____________________ State ______ City _____________________ State ______

You can use this form to indicate your choice to be an organ donor. Or you can designate it on your driver's license or state identification card (at your nearest driver's license office).

The card below may be used as a convenient method to inform others of your health care advance directives. Complete the card and cut it out. Place in your wallet or purse. You can also make copies and place another one on your refrigerator, in your car glove compartment, or other easy to find place.

Health Care Advance Directives

I, ______________________________

have created the following Advance Directives:

___ Living Will

___ Health Care Surrogate Designation

___ Anatomical Donation

___ Other (specify) __________________

---------------------- FOLD ---------------------------

Contact:

Name ________________________

Address ________________________

____

____

Phone ________________________

Signature ________________ Date _____

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