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

Estimado Nuevo Paciente,

Bienvenido! Gracias por elegir Archer Family Health Care, un servicio de UF College of Nursing. Adjunto se encuentra el paquete de nuevo paciente. Le pedimos que complete todas las páginas a fondo y lo traiga con usted a su cita. Si usted toma cualquier medicamento recetado o sin receta, por favor traiga su (s) frasco(s), incluso si están vacíos, con usted. Tendrá que llegar 20 minutos antes para el procesamiento de su paquete y conocer al personal clínico antes de su cita.

Estamos ubicados en 16939 SW 134th Ave en el centro de Archer. Si usted conduce sobre la carretera 27/45 al norte, gire a la izquierda en SW134th Ave. Si usted está conduciendo hacia el sur, gire a la derecha. Conduzca aproximadamente 2 décimos de milla. Estamos ubicados en el lado izquierdo de SW 134th Ave.

Nos esforzamos por ver a nuestros pacientes a tiempo y su puntualidad es apreciada. Si su espera es de más de 20 minutos, por favor avise a la persona en la recepción.

Se requiere un aviso de cancelación de 24 horas. Sin embargo, si surgen circunstancias y necesita cambiar su hora de cita, por favor concédanos el máximo de aviso para permitir que otra persona sea programa en el tiempo reservado para usted.

Por favor traiga su identificación con foto y la información de su seguro médico con usted. Nosotros facturaremos a su compañía de seguro. Sin embargo, usted será responsable de servicios no cubiertos, servicios fuera de red, deducibles, coseguros y/o copagos.

Si usted está aplicando para el programa de Pago Reducido, la verificación de su estado financiero y el total de ingresos del hogar será requerida para determinar su copago. Si la información requerida no es proporcionada se le cobrara la tarifa completa por los servicios otorgados.

El pago se realiza en el momento que los servicios le son otorgados. Aceptamos efectivo, y tarjetas de crédito/debito.

Puede visitar nuestro sitio web en http://afhc.nursing.ufl.edu para obtener más información sobre Archer Family Health Care.

Gracias por elegir nuestro equipo de atención medica!

Conozca nuestro equipo:
APRNs: Denise Schentrup, DNP, APRN, Directora Clinica; Ashley Kairalla MSN, APRN, FNP-BC; Kimberly Castillo, MSN, APRN; Stacia Hays, DNP, APRN, CPNP, CCTC; Chris Schrier, DNP, APRN, CPNP-PC; Karen Rye, MSN, APRN-MH
Trabajadora Social Clinica: María Colon, MSW, LCSW
Medico consultante: David Feller, MD
Gerente de la práctica: Joan N. Walker, CMM, CPM

Personal de Apoyo Clínico
Chikako Alvarado, LPN
Johnna Bullard, LPN

Personal Administrativo
Dawn Alexander, CPB, RHC-CBS, Coder I
Ana Ortiz, Representante de Servicio Clínico I
Shana Perry-Walker, CMA
Thomas E. Metcalfe Jr., MBA

Información del Paciente

Fecha del día de hoy:		
Nombre del Paciente:		Fecha de nacimiento: PT ID:
Nombre de preferencia/ Apodo:		
Dirección: Ciudad: Estado: Código Postal: Condado: Número de teléfono: Número de Celular: Número del Trabajo:		
Sexo:	Numero de Seguro Social:	[ ] Veterano
Estado Civil : [ ] Divorciado/a [ ]Soltero/a [ ]Casado/a [ ]Otro		
Si es casado, nombre de su esposo/a: Primer Nombre:_____ Apellido :_____ Fecha de Nacimiento:_____		
Correo electrónico:	Mejor forma de contacto: [ ] Casa/Celular [ ] Trabajo [ ] Correo electrónico	
Referido por::	Cuidado primario:	
Idioma preferido:		
Raza: [ ] Afro Americano/Negro [ ] Caucásico/ Blanco [ ] Asiático [ ] Indio Americano/ Nativo de Alaska [ ] Nativo de Hawái [ ] Otro isleño del Pacifico [ ] Más de una raza (elija ambas) [ ] Otra _____		
Etnia: [ ] Hispano o Latino [ ] No Hispano o Latino [ ] Otra o indeterminada [ ] Paciente se niega a contestar		
Empleo: [ ] Empleo de tiempo completo [ ] Empleo de medio tiempo [ ] Estudiante de tiempo completo [ ] Estudiante de Medio tiempo [ ] Desempleado [ ] Jubilado [ ] Discapacitado	Empleador o Escuela _____ Dirección: _____ _____ Teléfono: _____	
Contacto en caso de emergencia:		
Teléfono:	Relación con Usted:	
Número total de miembros familiares de su hogar: Asegurado o no asegurado		
Ingresos del hogar $	Por [ ]Mes [ ]Semana [ ] Año	Fuente de Ingresos:
Información de Seguro Principal		
Nombre de la Compañía de Seguro:		
Nombre del Asegurado: Primer nombre: Segundo nombre: Apellido:		
Fecha de nacimiento del asegurado: Identificación del asegurado: Otra identificación:		
Numero de Póliza: Numero de Grupo: Nombre del Grupo:		
Información de Seguro Secundario		
Nombre de la compañía de Seguro:		
Nombre del asegurado: Primer nombre Segundo nombre: Apellido:		
Fecha de nacimiento del asegurado: Identificación del asegurado: Otra identificación:		
Numero de Póliza: Numero de Grupo: Nombre del Grupo:		
_____, Está autorizado/a para recibir información médica protegida en mi ausencia o en mi nombre. Entiendo que esta autorización permanecerá vigente por un (1) año o hasta que la revoque por escrito (es decir, comunicarle a Archer Family Health Care que la cancele). Firma del paciente/Representante: _____ Fecha: _____		

Formulario de Historia de Salud Pediátrica- Visita Inicial

Nombre del niño/a:_____ **Fecha de Nacimiento**: _____ **Edad**: _____

Historia médica pasada del niño/a

Embarazo/Periodo Neonatal

¿La madre utilizo alguna droga o alcohol durante el embarazo?
__No __Sí Si sí, explique_____
¿Dónde nació su hijo/a?
Es hijo/a suyo/a por ____nacimiento ____adopción ____hijastro/a ____otro
Complicaciones del embarazo:
_____
_____
¿Fue prematuro su hijo/a? ____No ____Sí nació a las ____ semanas
Parto ____vaginal ____Cesárea
Peso al nacer_____ Medida al nacer_____
¿Algún problema durante el período de recién nacido?
_____
_____

Infancia/Niñez/Adolescencia

__ Alergias
__ Asma o enfermedad reactiva de las vías respiratorias
__ Anemia
__ Trastornos de coagulación
__ Cáncer
__ Depresión
__ Diabetes
__ Fracturas o roturas
__ Síndrome genético
__ Reflujo acido
__ Enfermedad cardiaca o soplo cardiaco
__ Enfermedad del riñón
__ Migrañas o Dolores de cabeza
__ Problemas de visión o audición
__ Enfermedad de Transmisión Sexual
__ Convulsiones
__ Lesiones deportivas (conmoción cerebral, etc.)
__ Otro _____

¿Alguna vez su hijo/a ha sido hospitalizado/a?
__ No __ Sí, Explique
_____
Cirugías anteriores y fechas_____
_____
Por favor anote los especialistas que su hijo/a está viendo actualmente y las razones:
_____
_____

Medicamentos

ALERGIAS a medicamento o vacunas (enliste y describa la reacción)_____
_____
_____
Medicamentos y dosis ACTUALES_____
_____
_____

Vitaminas/Suplementos/Medicamentos sin receta___
_____
_____

Desarrollo/Nutrición

A qué edad su hijo/a hizo lo siguiente:
_____ caminar solo/a _____ sentarse solo/a
_____hablar _____Fue al baño solo/a
¿Su hijo/a fue amamantado? ___ No ___Sí
por _____ meses
Su hijo/a ha tenido problemas alimenticios:_____
_____
Consumo de leche actual: Tipo: _____
Cantidad por día_____

HISTORIA SOCIAL

Quien vive en la casa con su hijo/a? ___ Mamá
___Papá___Padrastro/madrastra
___ Hermanos(#_____) ___Abuelos ___ Otro
Los papás de niño son: ___ Casados ___
Solteros___Divorciados
___ Otro: _____
Cuidado infantil:_____
Días de la semana en guardería (No con los papás)
_____
Algún miembro de la casa fuma? ___ Sí ___ No
¿Cuantas bebidas con cafeína (té café, cola) consume su niño/a por día?_____
¿Cuantas horas al día pasa su niño/a frente a una pantalla (TV, computadora, Ipod, Ipad, etc)? _____
¿En qué grado se encuentra su hijo/a?_____
¿Hay alguna preocupación sobre el desempeño escolar de su hijo/a?_____
¿Alguna preocupación sobre las relaciones con compañeros o maestros?_____
Deportes/ejercicio: Tipo_____
¿Con que frecuencia? _____ Por cuanto tiempo _____min

HISTORIAL FAMILIAR

Algún miembro de la familia tiene una alguna de las siguientes condiciones:

Condición	Madre	Padre	Hermano/a	Abuelo/a
Asma	__	__	__	__
Anemia	__	__	__	__
Ansiedad	__	__	__	__
Trastorno de coagulación	__	__	__	__
Cáncer	__	__	__	__
Depresión	__	__	__	__
Diabetes	__	__	__	__
Enfermedad del corazón	__	__	__	__
Colesterol Alto	__	__	__	__
Enfermedad del Riñón	__	__	__	__
Migrañas	__	__	__	__
Enfermedad de Tiroides	__	__	__	__
Convulsiones	__	__	__	__
Abuso de alcohol/Drogas	__	__	__	__
ADHD	__	__	__	__

Nombre del niño/a: _____ Fecha de nacimiento: _____**Edad: _____**

POR FAVOR COMPLETE ESTA SECCION SI TIENE MAS DE 12

¿Eres activo/a sexualmente? ___ No ___ Sí

Alguna vez se ha sentido físicamente, verbalmente, o emocionalmente maltratado, o ha sido golpeado, pateado o abofeteado? _____ No ____ Sí
explique_____

Niños Solamente: ___ Llagas en el pene ___ Hinchazón de los testículos ___ Secreción del pene

Niñas Solamente: ___ Secreción vaginal ___ Periodos irregulares ___ Sangrado vaginal inexplicable

Edad a la primera menstruación: _____

Periodos ocurren cada _____ semanas

Periodo dura _____ días

Último período menstrual:_____

Número de embarazos:_____

Número de niños vivos:_____

Número de abortos:_____

Número de abortos espontáneos:_____

Cualquier otra cosa que desee discutir con su proveedor de atención medica:

_____

_____

Su nombre: _____Relación con el niño/a _____

Paciente/Firma de la parte responsable _____ Fecha:_____

CONSENTIMIENTO PARA OBTENER HISTORIAL DE MEDICAMENTOS

Patient ID:_____

Como usuario de expedientes médicos electrónicos, su proveedor de Archer desearía incluir su historial de medicamentos en su registro. Un historial de medicamentos es una lista de medicamentos recetados que nosotros u otros médicos le han recetado. Esta lista se recopila de varias fuentes, incluyendo su farmacia y su seguro de salud.

Un historial exacto de medicamentos es muy importante para ayudarnos a tratarlo y evitar interacciones potencialmente peligrosas. Al firmar este formulario de consentimiento, usted nos da permiso para recolectar, y le da a su farmacia y su seguro de salud permiso para darnos información sobre sus recetas que han sido surtidas en cualquier farmacia o cubiertas por cualquier plan de seguro de salud. Esto incluye medicamentos recetados para tratar SIDA/VIH y los medicamentos usados para tratar afecciones mentales, como la depresión. Esta información de volverá parte de su historial médico electrónico, si su proveedor considera que es importante para su atención médica.

Este historial de medicamentos es una guía útil, pero puede que no esté completa. Algunas farmacias no ponen a nuestra disposición el historial de medicamentos, y el historial de medicamentos puede no incluir medicamentos sin receta, suplementos o remedios herbales. Aún así, es muy importante que nos tomemos el tiempo para discutir todo lo que está tomando y para que nos notifique de cualquier error en el historial de su medicamento.

____ Yo doy permiso a Archer Family Health Care para obtener mi historial de medicamentos de mi farmacia, mi seguro de salud y de mi otro proveedor de atención médica.

_____ Yo NO DOY permiso para que Archer Family Health Care obtenga mi historial de medicamentos de mi farmacia, mi seguro de salud y mis otros proveedores de atención médica.

Nombre del Paciente: _____ Fecha de nacimiento: _____

_____ _____

Firma del paciente o tutor Relación con el paciente

_____

Firma del empleado testigo

_____

Fecha

2018-19 Solicitud de Co-Pago de atención de Salud

En base a la información que proporciono, parece que puede calificar para un co-pago reducido. Por favor llene el siguiente formulario completamente y honestamente. Enliste todos los ingresos de todas las fuentes, incluyendo trabajo por cuenta propia, contribuciones de amigos/familiares, beneficios de Seguro Social, pensión, intereses, dividendos, manutención de hijos, beneficios de veteranos, desempleo/Compensación de trabajos de Rail Road Retirement, anualidades/alquiler, otra ayuda gubernamental. Enliste todo tipo de bienes incluyendo efectivo, cuenta bancaria, cuenta de ahorro, propiedad/ tierra, automóviles, camiones, motocicletas, barcos, seguros de vida, acciones, CDs.

Nombre: _____ **# SS:** _____ **Fecha de nacimiento:** _____ **ID del paciente:** _____

********** Miembros del Hogar**********

Enlístese usted mismo y los miembros de su hogar incluyendo su relación ellos. Anote el ingreso mensual de cada miembro de la familia. Si un miembro no tiene ingresos anote la razón. Indique si un miembro tiene Medicaid o cupones alimenticios. Todos los pacientes que solicitan servicios reducidos deben solicitar Medicaid y cupones alimenticios. Si un miembro no tiene Medicaid o cupones alimenticios, indique el motivo de la denegación

Nombre del miembro	Relación con Usted	Fecha de nacimiento	Ingresos mensuales y fuente	Medicaid o cupones alimenticios

Derechos y Responsabilidades para la Asistencia Financiera Asistida

Archer Family Health Care brinda attención medica con cargos reducidos. Los cargos se basan en información de ingresos y bienes. Los servicios se proveerán con un cargo de $10.00 a personas que en las guías de la Pobreza Federal o por debajo de ellas y se aplicaran tarifas reducidas hasta el 200% de las guías de Pobreza.

Estoy aplicando para un co-pago reducido para poder recibir mi atención medica en Archer Family Health Care. Entiendo que los servicios de co-pago reducido no aplican a laboratorios externos o referidos para servicios otorgados fuera de Archer Family Health Care. Entiendo que debo dar información verdadera y completa en este formulario bajo pena de perjurio y puedo ser enjuiciado si miento u oculto información.

Estoy de acuerdo en que Archer Family Health care y University of Florida College of Nursing pueden verificar la información que he dado en este formulario. Estoy de acuerdo en que pueden contactar a mis empleadores actuales y pasados si se relacionan con mi elegibilidad. Estoy de acuerdo que pueden obtener información que afecta mi elegibilidad de cualquier registro o fuente, incluyendo el intercambio con otras agencias.

Estoy de acuerdo en notificarle a Archer Family Health Care de cualquier cambio de mi situación inmediatamente.

He leído I conservado una copia de mis derechos y responsabilidades. Declaro que la información proporcionada en este formulario es verdadera a mi saber y entender. Si ha reportado información falsa en esta aplicación, usted será despedido/echado de Archer Family Health Care.

_____ _____

Firma del paciente/tutor Fecha

_____ _____

Testigo Fecha

Política de Responsabilidades del Paciente

Comprobantes de Ingresos

1. Los pacientes sin seguro médico, que desean ser considerados para recibir atención a un costo reducido, deben proporcionar comprobantes del total de ingresos del hogar cada año. Si no se proporciona el comprobante de ingresos en la primera cita, el personal de la oficina le recordara al paciente para que lo entregue en la siguiente cita. Si los comprobantes no se proporcionan en la segunda cita, no se programaran citas a futuro hasta que los comprobantes sean entregados a la práctica. Como recordatorio de que todavía se necesitan los comprobantes de ingresos, el administrador de la oficina enviara una carta al paciente solicitando dicha información. Si todavía así la información no es proporcionada, se brindara atención de urgencia por un periodo de 30 días y el paciente recibirá una carta de expulsión de la práctica.

El pago se debe a la hora que los servicios son brindados

2. De acuerdo al contrato entre pacientes y las compañías de seguros médicos, los copagos, deducibles y los servicios no cubiertos se deben pagar en el momento en que los servicios son brindados. Si un paciente no tiene seguro médico, la cuota de la cita proporcionada por el personal de la oficina se debe pagar en el momento del servicio. Aceptamos tarjetas de debito/crédito y efectivo.

Acuerdo de pago por saldo vencido

3. Si un paciente desea establecer un plan de pago en lugar de pagar la totalidad de los servicios brindados, el paciente debe solicitar hablar con el gerente de la oficina. El gerente de la oficina determinara un plan apropiado basado en los ingresos del paciente. El paciente y el gerente de la oficina acordaran el monto del pago y la fecha en que el pago se debe de acuerdo con el plan de pago o los pagos cada mes. Es responsabilidad del paciente ponerse en contacto con el gerente de la oficina para discutir cualquier situación imprevista que pueda impedir pagos puntuales.

   El gerente de la oficina se comunicara con los pacientes que tengan saldos vencidos el 20 de cada mes como un recordatorio de la cantidad vencida. Si después de 3 meses consecutivos no hay actividad de pago del paciente, se le notificara al paciente que Archer Family Health Care proporcionara solo atención urgente por un periodo de 30 días hasta que el paciente se reúna con el gerente de la oficina para establecer un nuevo plan de pago.

Cancelación de Citas

4. Cancelación o reprogramación de citas requiere de una notificación de 24 horas.

Falta a citas

5. Un a falta a las citas ocurre cuando un paciente no cancela o reprograma una cita con al menos 24 horas de notificación. Si un paciente acumula 3 faltas a citas, el paciente recibirá una carta de expulsión de la práctica, la expulsión será por un periodo de un año. Si al final del año el paciente desea volver a la práctica, el paciente será aceptado como Nuevo paciente. Si un paciente no cancela o reprograma dos citas con una notificación adecuada, se le enviara una carta explicando con se manejaran las solicitudes de citas a futuro.

Adherencia al tratamiento

6. El cuidado de salud es una asociación entre el paciente y el proveedor de atención médica. Es responsabilidad del proveedor discutir opciones de cuidado y recomendar el plan de cuidado ideal a cada paciente. Es responsabilidad de los pacientes adherirse al plan de atención acordado. Si un paciente no se adhiere al plan de cuidado después de discutirlo con el proveedor, el proveedor puede expulsar al paciente de la práctica.

He leído la Política de Responsabilidades del Paciente anterior, y acepto cumplir con los términos.

_____ _____

Firma del paciente o Tutor Fecha

_____ _____

Nombre del paciente o tutor Fecha de Nacimiento

UF College of Nursing
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 _____ Insured _____
(If other than patient) (If other than patient)

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

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:

Name _____

Date _____

DOB _____

This is the template for Archer Family Health Care

UF | UNIVERSITY of FLORIDA

Archer Family Health Care
A Service of the College of Nursing

16939 SW 134 Ave
Archer FL 32615
352-265-2550
352-627-4785 Fax

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

Record Request: Authorization to Use and Disclose Protected Health Information ("PHI") Maintained by UF Health*

**For purposes of this agreement, UF Health describes a collaboration of the University of Florida Board of Trustees for the benefit of the University of Florida College of Medicine, Shands Jacksonville Medical Center, Inc., Shands Teaching Hospital and Clinics, Inc., and Shands Recovery, LLC. Collectively, these entities are referred to as UF Health in this form.*

Patient's Name	Date of Birth	Medical Record #	Verification of Identity
			☐ Driver License/State ID ☐ Personally known ☐ Other:
Patient's Address / City / State / Zip			
Phone #	Last 4 digits of SSN (Optional)		☐ Check if patient is an employee of UF Health Shands

Complete the section below *only* if the person requesting records is not the patient:

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

By signing this form, I authorize the release of PHI (i.e., medical records) as follows:

From the doctor, office, facility of other health care provider checked or written below:

☐ University of Florida person, class of persons, or organization:

Archer Family Health Care
Clinic, person, class of persons, or organization

16939 SW 134th Ave Archer FL 32618-5413
Address

P:352-265-2550 F:352-627-4785
Phone Attn

☐ **UF Health Shands Hospital** ▪ PO Box 100345, Gainesville, FL 32610-0345
Phone: 352.265.0131 ▪ Fax: 352.265.1098

☐ **UF Health Shands Rehab Hospital** ▪ 4101 NW 89th Boulevard, Gainesville, FL 32606
Phone: 352.265.5491 ▪ Fax: 352.627.4425

☐ **UF Health Shands Psychiatric Hospital** ▪ 4101 NW 89th Boulevard, Gainesville, FL 32606
Phone: 352.265.5497 ▪ Fax: 352.627.4425

☐ **UF Health Florida Recovery Center** ▪ 4001 SW 13th Street, Gainesville, FL 32608
Phone: 352.265.5500 ▪ Fax: 352.265.5504

☐ **UF Health Shands HomeCare** ▪ 3515 NW 98th Street, Gainesville, FL 32606
Phone: 352.265.0789 ▪ Fax: 352.265.9276

To the facility / person below:

Clinic, person, class of persons, or organization | Address and Fax Number | ☐ Check here if same as patient ☐ Check here for records pick-up only

Attn:

The following PHI may be released *(describe in detail or use the check boxes below)*:			**I further authorize the release of the following information which may be included in the PHI:**
☐ History and Physical	☐ Operative Reports(s)	☐ Discharge Summary	☐ Mental Health/Psychiatric Treatment
☐ Problem List	☐ Medication List	☐ Treatment Notes	☐ Alcohol or Substance Abuse Treatment
☐ Emergency Room Record	☐ Radiology Reports/Films	☐ Lab/Pathology Reports	☐ STD/HIV/AIDS Treatment(s) or Test(s)
			☐ Genetic Testing
Is this needed for a doctor's appointment?	Write date below:	**Are there specific dates needed?**	Write dates below:

Purpose of this request?	☐ Treatment/Continued Care ☐ Payment/Billing ☐ Personal Use ☐ Other:
Format of Records?	☐ Through a web portal, with notice provided to my e-mail account at: _____ To request records in electronic PDF form, please check the box above and provide a valid and clear e-mail address. You will receive an e-mail from HealthPort and that e-mail will tell you how to get the records. ☐ Paper

This authorization allows UF Health to use and disclose (release) certain PHI, which includes medical records, as I have directed.

I understand that:

- The PHI may include information about mental health, substance and/or alcohol abuse, HIV/AIDS, and STDs.
- This authorization may be used to share the same type of PHI indicated above which may be created in the future, until the expiration date.
- This authorization will remain in effect for **one (1) year** or until I revoke it in writing (i.e., tell UF Health to cancel it).
- I have the right to revoke this authorization at any time, if I do so in writing to the Health Information Management Department at the organization named above and that the revocation will not apply to action already taken as a result of this authorization.
- I may refuse to sign this authorization and doing so will not affect my treatment, payment, enrollment, or eligibility for benefits or the quality of care that I will receive.
- I understand that PHI released per this authorization may no longer be protected by state law or the federal health privacy law and could be re-disclosed by the person or entity that receives it.
- I am aware that I may be charged a fee for this request as allowed by law, which may include up to $1.00 per page (plus applicable tax and handling) for Paper Records and fees associated with labor, supplies (i.e. cost of a computer disk), and postage for Electronic Records. Fees are waived when PHI is released to a health care provider for treatment purposes.

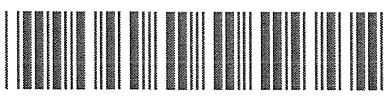
Signature of patient / patient representative _____ **Date** _____

UFHealth UNIVERSITY OF FLORIDA HEALTH UF UNIVERSITY of FLORIDA

Authorization for Use or Disclosure of Protected Health Information

Distribution: Original – Patient Record; Copy – Requestor

Revised 3/11/15
PS46283



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JOINT NOTICE OF PRIVACY PRACTICES
AND NOTICE OF ORGANIZED HEALTH CARE ARRANGEMENT

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW HEALTH 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 either the Privacy Office for UF Health Shands or the Privacy Office for the University of Florida at the contact information listed below:

UF Health Shands Privacy Office 1-866-682-2372

University of Florida Privacy Office 1-866-876-4472

OUR LEGAL DUTY TO PROTECT HEALTH INFORMATION ABOUT YOU

We understand your health information is personal and we are committed to protecting it. We create a record of the care and services you receive at UF Health Shands or the University of Florida Health Science Center (UFHSC) 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 UF Health Shands and/or the UFHSC, whether made by hospital personnel, University of Florida faculty, staff, students, or your personal doctor. This Notice describes how we may use and disclose your health information, and provides examples where necessary. This Notice also describes your rights regarding your health information.

We are required by law to maintain the privacy of health information, to provide individuals with notice of our legal duties and privacy practices with respect to health information, and to abide by the terms of the notice currently in effect.

CHANGES TO THIS NOTICE

We reserve the right to change our privacy practices and this notice at any time. We reserve the right to make the revised 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 at all our facilities.

NOTICE OF ORGANIZED HEALTH CARE ARRANGEMENT

UF Health Shands, which for the purposes of this notice includes Shands Teaching Hospital and Clinics, Inc. and Shands Jacksonville Medical Center, Inc., and the UFHSC, together with the UFHSC clinics* and other affiliated health care providers have agreed as permitted by law, to share your health information among themselves for purposes of treatment, payment or health care operations. This arrangement enables us to better address your health care needs in the integrated setting found within UF Health Shands and the University of Florida health care providers.

The organizations participating in the Joint Notice are participating only for the purposes of providing this Joint Notice and sharing medical information as permitted by applicable law. These organizations are not in any way providing health care services mutually or on each other's behalf. UF Health Shands and the University of Florida are separate health care providers and each is individually responsible for its own activities, including compliance with privacy laws, and all heath care services it provides.

CONSISTENT WITH STATE AND FEDERAL LAW, WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN PERMISSION IN THE FOLLOWING CIRCUMSTANCES:

We may use and disclose your health information to **provide medical treatment to you and to coordinate or manage your health care and related services**. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. For example: we may use and disclose your health information when you need lab work or an x-ray. Also, we may use and disclose your health information when referring you to another health care provider or to recommend treatment alternatives to you.

We may use and disclose your health information to **bill and receive payment for services rendered**. For example: A bill may be sent to you or your insurance company. The items on, or accompanying, the

bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used so that your health plan will pay the medical bill. We may also tell your health plan about a treatment you are expected to receive in order to obtain prior approval or to determine if your health plan will pay for that treatment.

We may use and disclose your health information for **health care operations**. We will use your health information for regular operations of the hospital and clinics to provide patients with quality care. For example: Members of the medical staff, the risk management team or the quality improvement team, including Patient Safety Organizations (PSOs), may use information in your health record to assess the care you receive and the outcomes of your treatment. We may also disclose information to doctors, nurses, technicians, medical students and other UFHSC personnel for review and teaching purposes.

We may also use and disclose your health information:

- When necessary to **prevent a serious threat to your health and safety** or the health and safety of the public or another person.
- To **organizations that facilitate donation and transplantation** of tissues and/or organs.
- To **authorized officials** when **required by federal, state, or local law.**
- In response to a **subpoena, court, or other administrative order**.
- As required by law, for **public health activities.** For example: preventing or controlling disease, reporting births and deaths, and reporting abuse and neglect.
- For authorized **Worker's Compensation activities.**
- To **health oversight agencies.** For example: agencies that enforce compliance with licensure or accreditation requirements.
- To **coroners, medical examiners, or funeral directors** to carry out their duties.
- As required by **military command authorities,** if you are a member of the armed forces.
- To our **business associates** to carry out treatment, payment, or health care operations on our behalf. For example: we may disclose health information about you to a company who bills insurance companies for our services.
- For **research or to collect information in databases to be used later for research**. All research projects are reviewed and approved by an independent review board to protect the privacy of your health information.
- To a **correctional institution having lawful custody of you** as necessary for your health and the safety of others.

We may also use and disclose your information for **fundraising activities** to raise money for UF Health Shands or UFHSC and their operations. If you do not want to be contacted for fundraising efforts, you must notify either the UF Health Shands Privacy Office or the University of Florida Privacy Office.

SPECIAL CIRCUMSTANCES

Alcohol, Drug Abuse, Psychotherapy Notes, and Psychiatric Treatment Information may have special privacy protections. We will not disclose any health information identifying an individual as a patient or provide information relating to the patient's substance abuse or psychiatric treatment unless:

1. You or your personal representative consents in writing;
2. A court order requires disclosure;
3. Medical personnel need information to treat you in a medical emergency;
4. Qualified personnel use the information for research or operations activities;
5. It is necessary to report a crime or a threat to commit a crime; or
6. To report abuse or neglect as required by law.

JOINT NOTICE OF PRIVACY PRACTICES AND NOTICE OF ORGANIZED HEALTH CARE ARRANGEMENT

YOU MAY REFUSE TO PERMIT CERTAIN USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Unless you object, we may use or disclose your health information in the following circumstances:

- **Hospital Directories**. We may share your name, room number, and condition in our patient listing with clergy and with people who ask for you by name. We also may share your religious affiliation with clergy.
- **Individuals Involved in Your Care or Payment for Your Care.** We may use or disclose information to a family member, legal representative, or other persons involved with or responsible for your care or the payment of your care.
- **Emergency Circumstances and Disaster Relief**. We may disclose information about you to an agency assisting in a disaster relief effort so that your family can be notified of your location and general condition. Even if you object, we may still share the health information about you, if necessary for emergency circumstances.

USES AND DISCLOSURES OF HEALTH INFORMATION THAT REQUIRE YOUR WRITTEN PERMISSION

Other uses and disclosures of health information not covered by this notice or applicable law will be made only with your written permission. If you provide permission to use or disclose health information, you may revoke that permission at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your revocation. We are unable to take back any disclosures already made with your permission.

We will not use or disclose your protected health information for marketing purposes, nor will we sell your protected health information without your written permission.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

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

- **Right to See and Obtain Copies of your Health Information**

  You have the right to see and obtain copies of health information used to make decisions about your care. Usually, this includes medical and billing records, and excludes psychotherapy notes.

  To view and copy your health information, you must submit your written request on the appropriate form to Health Information Management or the Clinic Manager. We may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to see and obtain copies of your health information in certain very limited circumstances. You have the right to appeal the denial.

- **Right to Amend**

  If you think that your health and billing information is incorrect or incomplete, you may ask us to correct it. We may deny your request if:

  1) The information was not created by us;
  2) The information is not part of the records used to make decisions about your care;
  3) We believe the information is correct and complete; or
  4) You do not have the right to review parts of the medical record under certain circumstances.

  We will tell you in writing the reasons for the denial and describe your rights to give us a written statement disagreeing with the denial.

  If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, as needed, including persons you name who have received information about you and who need the amendment. Your request must be in writing and include an explanation of your reason(s) for the amendment. The request must be submitted on the proper

form to the Health Information Management or Clinic Manager where you received treatment.

- **Right to an Accounting of Disclosures**

  You have the right to request an Accounting of Disclosures. This Accounting of Disclosures report does not include disclosures made for your treatment, payment, or health care operations. It also does not include disclosures made to or requested by you, or that you authorized.

  You must submit your request for a report in writing to the Health Information Management or the Clinic Manager where you received care. Your request must state a time period, which is limited to the previous six years from the date of the request. The first request for an accounting of disclosures will be provided free of charge. We may charge you for additional report requests made within a 12 month period.

- **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. If we agree with your request, we will comply unless the information is needed to provide emergency treatment, is required by law, or otherwise required to be disclosed as listed in this notice.

  You must make your request for restrictions in writing to either the UF Health Shands Privacy Office or the UF Privacy Office. Your request must include what information you want to limit and how you want the limits to apply.

  You have the right to restrict disclosures of health information made to a health plan when the items or services were paid in full prior to being rendered. Certain limitations apply.

- **Right to Choose How We Communicate With You**

  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. You must make your request for alternate communications in writing to the Admissions supervisor at UF Health Shands, or to the UF Clinic Managers or supervisors. We will not ask you the reason for your request and will accommodate reasonable requests.

- **Right to a Paper Copy of This Notice**

  You have the right to receive a copy of this notice from UF Health Shands or any UF clinic. You may obtain an electronic copy of this notice from our websites at: https://ufhealth.org/patient-care or www.privacy.health.ufl.edu.

- **Right to Breach Notification**

  You have the right to and will receive notification in the event of a breach of your unsecured protected health information, unless such notification is exempted by law.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us. You will not be penalized or denied services for filing a complaint. To file a privacy complaint with UF Health Shands, please contact the Privacy Office, at, P.O. Box 103175, Gainesville, FL 32610-3175, or call 1-866- 682-2372. To file a privacy complaint with the UFHSC or UF Clinics, please contact the UF Privacy Office at P.O. Box 113210, Gainesville, FL 32611 or call 1-866-876-4472. All complaints must be submitted in writing on the appropriate form that is available on our website: www.privacy.health.ufl.edu. To file a complaint with the Secretary of the Department of Health and Human Services, visit the Office for Civil Rights website at www.hhs.gov/ocr.

*The University of Florida clinics and physicians' offices; the Florida Clinical Practice Association; the University of Florida Jacksonville Physicians, Inc., the University of Florida Jacksonville Healthcare, Inc.; the University of Florida Colleges of Medicine, Nursing, Health Professions, Dentistry and Pharmacy; the University Proton Therapy Institute; and other affiliated health care providers, including all employees, volunteers, staff and other University of Florida health services staff.