



Payment Information for Health Care Services



2309 East 15th Street, Panama City, Florida 32405 (850) 747-5272 / FAX: (850) 747-5274
479 East Highway 20, Freeport, Florida 32439 (850) 880-6568 / FAX: (850) 880-6583

PATIENT INFORMATION

Last Name		First Name		Middle Initial	
Social Security Number		Date of Birth		U.S. Military Service (<input checked="" type="checkbox"/> one): <input type="checkbox"/> None <input type="checkbox"/> Currently Serving <input type="checkbox"/> Discharged	
Address		City		State	
				Zip Code	
				County	
Home Phone ()		Work Phone ()		Cell Phone ()	
				Sex <input checked="" type="checkbox"/> : <input type="checkbox"/> F <input type="checkbox"/> M	
Marital Status (<input checked="" type="checkbox"/> one): <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		Primary Language Spoken:		Patient's relationship to responsible party (<input checked="" type="checkbox"/> one) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Natural Child <input type="checkbox"/> Parent <input type="checkbox"/> Foster Child <input type="checkbox"/> Foster Parent	
Please answer both questions. 1. RACE <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Latino <input type="checkbox"/> Asian Pacific Islander <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Undocumented 2. ETHNICITY <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic					
Emergency Contact			Phone ()		Relationship to Patient

RESPONSIBLE PARTY INFORMATION (enter name of person FINANCIALLY responsible for your account)

Last Name		First Name		Middle Initial	
Street Address		City		State	
				Zip Code	
				County	
Mailing Address		City		State	
				Zip Code	
				County	
Home Phone ()		Work Phone ()		Income: \$_____ PER: <input type="checkbox"/> Week <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Month <input type="checkbox"/> Year	
Employer Name			Employer Address		
Social Security Number		Birth Date		Sex <input type="checkbox"/> F <input type="checkbox"/> M	
				Marital Status (one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	

INSURANCE COMPANY – INCLUDING MEDICAID

Primary Insurance		ID#		Group #		Insurance Company Address	
Name of Insured		Date of Birth		Insured's Employer			
Relationship to Responsible Party: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Natural Child <input type="checkbox"/> Step Child Parent <input type="checkbox"/> Foster Child <input type="checkbox"/> Foster Parent							
Secondary Insurance		ID#		Group #		Insurance Company Address	
Name of Insured		Date of Birth		Insured's Employer			
Relationship to Responsible Party: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Natural Child <input type="checkbox"/> Step Child Parent <input type="checkbox"/> Foster Child <input type="checkbox"/> Foster Parent							

Assignment and Release: I authorize my insurance benefits to be paid directly to the Community Health Center. I also authorize the Community Health Center to release any information required to process this claim.

SIGNED: X _____ DATE: _____



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Patient Name: _____ Today's Date: _____
 Last First MI

Birth Date: _____

Health Information

Date of Last Medical Visit: _____ Reason for Visit: _____

Check those that apply to you:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Skin Cancers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug Addictions | <input type="checkbox"/> HIV/AIDS Risk or Exposure | <input type="checkbox"/> Sleeping Difficulties |
| <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Ear Discharge | <input type="checkbox"/> Injuries | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Earache | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bowel Changes | <input type="checkbox"/> Ecstasy use | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Cancer History | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Changing Moles | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Fractures | <input type="checkbox"/> Marijuana use | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Cholesterol (high) | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Marital Problems | <input type="checkbox"/> Transfusion |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoarthritis | When: _____ |
| <input type="checkbox"/> Cocaine use | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Coughing Up Blood | <input type="checkbox"/> Heart Attach | <input type="checkbox"/> Rectal Bleeding | |
| <input type="checkbox"/> Crystal Meth use | <input type="checkbox"/> Heart Cath | <input type="checkbox"/> Rheumatoid Arthritis | |
| <input type="checkbox"/> Dark or Black Stools | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sexual Difficulties | |

Last Pap Smear: _____
 Last mammogram: _____
 Number of Pregnancies: _____

Number of Births: _____
 Birth Control Method: None Pill Condoms IUD
 Shots Tubal Vasectomy Other _____

Hospitalization/Surgeries: _____

Medications: _____

Family History

Check those that apply to you:

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension or High Blood Pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | |

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have a change in my health, I will inform the doctors at the next appointment without fail.

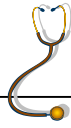
Date: _____

Signature of patient, parent or guardian

Date: _____

Doctor's Signature

Notice of Privacy Practices



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Our Notice of Practice Policies provides a description of our treatment, payment activities and healthcare operation. It also contains uses and disclosures we may make of your protected health information. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices at any time. If we do so, we will issue a revised notice of privacy practices.

Purposes: This form is used to obtain acknowledgment that you have been notified that our NOTICE OF PRACTICE POLICIES can be obtained via our office. (Community Health Center, 2309 East 15th Street, Panama City, Florida 32405 or 479 East Hwy. 20, Freeport, FL 32439) This document is printable via the website for your records. HIPPA website: <http://www.hhs.gov/ocr/hipaa/finalreg.html>

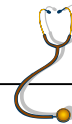
By signing this section, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

You have the right to revoke this consent at anytime by giving us a written revocation.

Signature

Date

Consent to Obtain Protected Health Information



Patient's Name: _____ Date of Birth: _____

I give my permission for _____ to release all protected health information
Healthcare Provider/Facility

to Community Health Center for the purpose of treatment and payment activities. This includes general medical reports, history and physicals, progress notes, diagnostic test reports, immunizations, prenatal records, consultations and any other information necessary for the purposes of treatment. This release includes information relating to STD's, HIV/AIDS, TB, Drug/Alcohol, Mental Health, WIC Eligibility & Early Intervention.

Health Care Provider/Facility: _____

Address: _____

Phone: _____ Fax: _____

Signature

Relationship to Patient

Date

Consent for Medical Treatment

Community Health Center **Dental Clinic**, 2309 East 15th Street, Panama City, Florida 32405 (850) 747-5272 / FAX: (850) 747-5274
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I hereby authorize PanCare of Florida, Inc., Community Health Center, its facilities or treatment centers, its affiliated physicians, ARNPs, physician assistants and other medical personnel to administer examinations and treatments as deemed medically necessary.

Parents with Minor Children: I understand that in order for my child (anyone under 18) to be seen by one of PanCare of Florida, Inc., Community Health Center’s medical professionals, a parent or legal guardian must be present.

Signature of Patient: _____ Date: _____

Relationship to Patient: _____ Date: _____

Witness Signature: _____

Broken Appointment Policy Agreement

Due to the increasing number of broken appointments at the medical clinic, it is necessary to enforce a broken appointment policy effective immediately.

It is the responsibility of the patient (or the parent, in the case of a child) to notify the medical staff any time they will not be available for their appointment, at least 24 hours prior to the scheduled appointment time. When scheduling two or more patients per family, 48 hours will be required prior to the cancellation of the scheduled appointment.

We must enforce a policy that after 2 broken appointments per person we will dismiss that patient, any siblings living in the same residence, or any adult responsible for that child’s medical treatment for one year from the date of their second broken appointment.

I have read and understand the above statement. By signing below, I acknowledge that I will make every effort to notify the medical staff at least 24 hours in advance if I will not be able to make my scheduled appointment. I also understand that if I or a family member breaks two appointments without notice, steps will be taken to dismiss me or my family members from this practice.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

