CONVENIENT CARE
PATIENT INTAKE FORM

Name/Nombre:	
Street Address/Dirección:	
City/Ciudad:	Postal Code/Código Postal:
Phone/Telefono: (home/casa)	(Cell/Celular) (Work/ Trabajo)
Email Address/Correo Electronico:	
Would you like to receive South Florida Injury and convenient Care emails regarding appointment Information? ¿Le gustaría recibir correos electrónicos de South Florida Injury and Convenient Care en referencia a su cita médica? Yes/Si ☐ No/No ☐	
Would you like to receive South Florida Injury and convenient Care texts regarding appointment Information? ¿Le gustaría recibir correos mensajes de texto de South Florida Injury and Convenient Care en referencia a su cita médica? Yes/Si ☐ No/No ☐	
Gender/Sexo *(circle)*: M F	Date of Birth/Fecha de Nacimiento:
Family Doctor/Medico Familiar:	
Preferred Pharmacy/Farmacia Preferida:	Phone Number/Telefono:
How did you discover this clinic? *(please circle)* ¿Como descubrio nuestra Clinica? *(Circule uno)*	Family Doctor | Specialist | Friend/Family | Website | Facebook | Attorney: _____ | Other *(please specify)*: Doctor Familiar | Radio | Amigo/Familia | Web | Facebook | Abogado: _____ | Otro *(especifiqué)*:

CHIEF COMPLAINT/MOTIVO DE CONSULTA:

_____

_____

_____

SOCIAL HISTORY/HISTORIAL SOCIAL:

___ Smoker/Fuma ___ Non-Smoker/No Fuma ___ Drink Alcohol/Bebe Alcohol
How much? _____
Cuanto? _____

___ Does not Drink Alcohol/No toma Alcohol

MEDICAL HISTORY/HISTORIAL MEDICO:

Do you have any of the following? /Tiene algunos de los siguientes?

Diabetes? /Diabetis?	Y/Si	N/No
Heart Trouble?/Problemas del Corazon?	Y/Si	N/No
Epilepsy? /Epilepsia?	Y/Si	N/No
High Blood pressure? /Pression Alta?	Y/Si	N/No
Circulation problems? /Problemas de Circulacion?	Y/Si	N/No
Osteoporosis?/Osteoporosis?	Y/Si	N/No
Bowel/Bladder Problems? /Problemas de Vejiga?	Y/Si	N/No
AIDS/HIV positive?	Y/Si	N/No
Have you ever had cancer? /Ha tenido Concer?	Y/Si	N/No
Have you ever experienced dizziness or blackouts?	Y/SI	N/No
Sudden weight loss? /Pérdida de Peso Repentino?	Y/Si	N/No
Breathing problems? /Problemas Respiratorios?	Y/SI	N/No
Are you pregnant?Esta Embarazada?	Y/SI	N/No
Recent surgery? /Cirujia Reciente?	Y/Si	N/No
Arthritis? /Artritis?	Y/Si	N/No

Describe any other health problems/Describa algún otro problema de Salud:

_____

_____

List of Past Surgeries/Lista de Cirujias Pasadas:

_____

_____

List any allergies/Allergias:

_____

_____

List all medications you are taking/Lista de medicamentos que esté tomando:

_____

_____

PATIENT CONSENT / ASSIGNMENT OF BENEFITS / AUTHORIZATION AND FINANCIAL RESPONSIBILITY DISCLOSURE STATEMENT

Consent to Use Protected Health Information for Purposes of Treatment, Payment, and Healthcare Operations – I consent to the use and/or disclosure of my protected health information (PHI) by South Florida Convenient Care, LLC (South Florida Injury Convenient Care) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct healthcare operations of South Florida Injury Convenient Care. I understand that diagnosis or treatment of me by South Florida Injury Convenient Care may be conditioned upon my consent as evidenced by my signature on this document.

Assignment of Benefits – I hereby assign any and all medical benefits to which I am entitled through my current insurance plan/plans to South Florida Injury and Convenient Care, 2601 Manatee Ave. W., Suite E, Bradenton, FL 34205. This assignment shall stay in effect until revoked by me in writing. A copy of this assignment is considered as valid as the original.

Financial Responsibility – I understand that I am responsible for all charges, whether or not I have insurance. I understand that I am responsible for the full amount due to South Florida Injury and Convenient Care billed unless a payment arrangement is negotiated with the South Florida Injury Convenient Care billing department.

Consent for Use and Disclosure of PHI – I understand that by signing this consent form, I am giving my consent to South Florida Injury and Convenient Care to use and disclose my protected health information to carry out treatment, payment activities, and health care operations. I have had full opportunity to read the South Florida Injury Convenient Care Notice of Privacy Practices. This PHI is being used or disclosed for the purpose of expediting communication of my treatment and care and shall remain in full force and effect for twelve months from the date recorded below. I understand that I have the right to revoke this authorization in writing at any time by sending such written notice to the practice's Privacy contact at 2601 Manatee Ave. W., Suite E, Bradenton, FL 34205. I understand that such revocation will not affect any previous claims submission or payments from my insurance provider for dates of service prior to my written notice.

Cancellation / Now Show Policy – South Florida Injury and Convenient Care understands that there are times when you must miss an appointment. Please understand that we (South Florida Injury and Convenient Care) reserves the right to charge a $25 dollar cancellation fee if an appointment is not cancelled at least 24-hours in advance.

Return Check Policy – A $50.00 fee will be charged for all returned checks.

Indicated below are individuals whom South Florida Injury and convenient Care may speak to regarding my treatment. Please enter the name of the individual in the space provided.

- Spouse: _____
- Family Member: _____
- Other: _____

Do we have your permission to leave a confidential message at the phone number(s) you provided to us?

□ Yes □ No □ Home □ Mobile □ Work □ Other: _____

I understand that I am responsible for knowing the details of my benefits and agree to pay charges for my visit.

_____ _____

Signature of Patient / Guardian / Responsible Party Date

_____ _____

Print Name of Patient/Guardian/Responsible Party Relationship to Patient (if applicable)

NOTICE OF PRIVACY PRACTICES

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
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization : In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

_____

Print Patient's Name Date

I,_____, acknowledge that I
(Signature of Patient or Parent or Legal Guardian)

Have either received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I,_____, consent to the use and disclosure of
(Signature of Patient or Parent or Legal Guardian)

My personal health information by your office for Treatment, Billing / Payment and Health care Operations as outlined in the NOTICE OF PRIVACY PRACTICES.