SULZBACHER VILLAGE
PEDIATRIC HEALTH CENTER

PATIENT REGISTRATION AND CONSENT FORM

Patient's Preferred Name:		
Patient's Legal Name (first, middle, last):		
Parent/Legal Guardian Name (first, middle, last):		
Address:		
City:	State:	Zip:
Patients Date of Birth:	Patients Social Security #:	
Home Phone:	Cell or Other Phone:	
E-mail Address:	Preferred Pharmacy:	

Number of individuals/family members living in household:	Average Annual Household Income:
Name of Emergency Contact:	
Relationship:	Contact Number:

Race	Gender Identity	Sexual Orientation	Residence Status
☐ Asian	☐ Male	☐ Straight	☐ US Citizen
☐ Native American	☐ Female	☐ Gay	☐ Legal Resident
☐ Other Pacific Islander	☐ Transgender Male	☐ Lesbian	☐ Immigrant Refugee
☐ Black/African American	☐ Transgender Female	☐ Bisexual	**Ethnicity**
☐ White	☐ Other	☐ Don't Know	☐ Hispanic
☐ More than one race	☐ Choose not to disclose	☐ Choose not to disclose	☐ Non-Hispanic

Please check any health insurance you currently receive

☐ Medicaid	☐ UF Health City Contract Card	
☐ Medicare	☐ Ryan White Health Insurance	☐ Any Other Insurance: _____
☐ Share of Cost Medicaid	☐ Private Health Insurance	☐ No Insurance

Does the patient currently smoke cigarettes?	☐ Yes	☐ No	☐ N/A
Has the patient ever smoked cigarettes?	☐ Yes	☐ No	☐ N/A

Is the patient currently homeless?	☐ Yes	☐ No
Has the patient been homeless in the last 12 months?	☐ Yes, please check all that apply below	☐ No
☐ Lived in transitional housing or treatment center	☐ Temporarily living with another family member or friend	
☐ Lived in a homeless shelter	☐ Lived on street or in car, park, sidewalk or abandoned building	

By signing this document, I confirm that this information correctly describes my child's insurance and living situation. I understand that giving false information may affect my ability to receive services. I understand that the Sulzbacher Clinic may check this information and I give them permission to do so. I understand that this consent form will be good until my child leaves/graduates school or until I provide the Center staff with written directions otherwise.

I allow the Sulzbacher Clinic to give treatment, perform exams/tests to find out what is wrong, take blood or other samples for lab tests (including HIV), teach my child about health-related topics, allow medical/nursing/dental students and residents/interns to help with care, allow providers to prescribe medicines and to obtain medication history information.

Printed Parent Name: (or legal representative)		**Date:**
Parent Signature: (or legal representative)		**Date:**

DISCLOSURE OF PROTECTED HEALTH INFORMATION AND PRIVACY AUTHORIZATION FORM

Patient Name Last:	**First:**	**Middle:**
Address:		
City:	**State:**	**Zip Code:**
SSN#:	**Date of Birth:**	**Tel. No:**

1. **Disclosure of Health Information for Treatment, Payment & Healthcare Operations**
I consent to the use and disclosure of my child's protected health information for treatment, billing and healthcare operations. I have read a copy of the Notice of Privacy Practices and understand that I have the following rights and privileges:
   - The right to review the Notice prior to signing the consent
   - The right to inspect and receive a copy of my child's clinical information
   - The right to request to amend clinical information I feel is incorrect or incomplete
   - The right to request that Sulzbacher restricts the use and disclosure of my child's personal health information
   - The right to revoke my permission at any time by giving written notice to Sulzbacher

   This authorization will remain in effect until my death or the day I withdraw my permission (in writing)
   I would like to receive a copy of the Notice of Privacy Practices ☐ Yes ☐ No

   I,_____, have read this consent form and the Notice of Privacy Practices. I understand that I am giving you consent to use and disclose my child's health information for treatment, billing and healthcare operations.

   _____ _____
   Signature of Patient/Legal Representative Date

2. **HIPAA Privacy Authorization Form: Who can see my child's health information?** Please list any family members or others who may be involved in coordinating your child's care.

Name	Relationship to Patient

How long can they see my child's information?
☐ From _____ to _____
☐ All past, present and future periods

What can they see? ☐ **Everything**	☐ **Everything EXCEPT the following (check all that apply)**
☐ Mental Health Records	☐ HIV/AIDS/Other Communicable Disease Records
☐ Alcohol/Drug Abuse Treatment Records	☐ Other, specify: _____

This medical information may be used by the person I authorize for medical treatment, billing or claims, discussions about my child's health, or other purposes that I allow.

I understand that I have the right to revoke this authorization (in writing) at any time. I understand that any revocation is not effective on any information that has already been shared. I understand that I can refuse to sign this release and that my treatment, payment, enrollment, or eligibility for services will not be withheld.

_____ _____
Signature of Patient/Legal Representative Date

SULZBACHER VILLAGE
PEDIATRIC HEALTH CENTER

Notice of Privacy Practices

This Notice of Privacy Practices describes how we use and disclose your health information, how you can get access to this information, your rights concerning your health information and our responsibilities to protect your health information. We are required by State and Federal laws to provide you with this Notice and we will comply with its terms during the period when it is in effect. The Notice will take effect on February 23, 2016 and will remain in effect until it is amended or replaced by the Health Services Administrator and Board of Directors. You have a right to a copy of any new revisions if they should become necessary.

Treatment: We may use clinical information about you to provide you with clinical treatment or services. We may also disclose clinical information about you to other doctors and/or specialty care providers, counselors, medical caseworkers or other authorized personnel involved in your care.

For example: A doctor may need to tell the specialty doctor who you were referred to about medication that was prescribed and if any medications need to be prescribed after your visit with the specialty doctor. We may share information with outside people if they are also responsible for services related to those you receive here.

For Payment: We may use and disclose clinical information about you so that treatment and services you receive at the center may be billed to and payment may be collected. This disclosure involves our billing staff, insurance organizations, collections and/or a third party payor.

For example: We may need to inform your health plan about treatment you are going to receive to obtain prior approval so your plan will cover treatment. We may need to share information with your insurance company about your treatment plan so your health plan will pay us or to reimburse you.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree

If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposed.

Other Uses of Your Clinical Information: Other uses and disclosures of clinical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us with written permission to use or disclose clinical information about you, you may revoke that permission, in writing, at any time.

If you revoke your permission, we will no longer use or disclose clinical information about you for the reasons covered in your written authorization.

We are unable to take back any disclosures we have already made with your permission.

We are required to retain our records of the care we provided to you.

Your Rights Concerning Privacy of Your Clinical Information: You have the right to inspect and receive a copy of your clinical information including clinical and billing records. To inspect and request a copy of your clinical information that may be used to make decisions about you, you must submit a request in writing.

If you request a copy, we may charge a fee to cover the cost of copying, mailing, or other costs of other supplies associated with your request.

You have the right to request to amend clinical information you feel is incorrect or incomplete. You may request an amendment for as long as we keep the information.

To request an amendment, your request including a reason to support the request, must be in writing.

We may deny the request for the amendment of clinical information. We may deny your request for amendment if it is not in writing.

We may deny your request for amendment if it does not include a reason to support the request.

We may deny your request for amendment if the information you are requesting to amend was not created by us; unless, the person that created the information is no longer available to make the amendment.

We may deny your request for amendment if it is not part of the information kept by the center.

We may deny your request for amendment if it is not part of the information you would be permitted to inspect.

We may deny your request for amendment if the information is accurate and complete.

For Health Care Operations:

We may use and disclose your Protected Health Information (PHI) for internal purposes regarding your care. ***For Example:*** *We may use information within our organization to acquire additional recommended treatment possibilities from other clinicians with other experience. Our organization may use information for learning purposes. Our organization may use information to evaluate the performance of our staff in providing services to you. We will use this information for appointment reminders. Our organization may use this information to tell you about treatment alternatives.*

We may disclose your PHI externally with appropriate releases as required. For Example: Our organization may release information to your insurance company, caregiver, or someone who helps pay for your care. Our organization may release information to disaster relief personnel to locate family or you if necessary. Our organization may combine information from our center with that of other centers for quality review and for evaluating services offered or for research. Our organization may remove information that identifies you from this information.

We will seek specific permission if researchers have access to information that would identify you. We will disclose information about you when required by federal, state, or local law.

Other uses and disclosures we are allowed to make without your explicit authorization. We may release information about you:

For public health activities: These would generally include: report of child or adult abuse or neglect, to notify people of recalls of products, to notify authorities of a victim of abuse, neglect, or domestic violence when authorized by the patient or required by law, and prevention or control of disease.

To a Health Oversight Agency as Authorized by Law

If you are involved in a lawsuit- in response to a court or administrative order, or in response to a subpoena, delivery request, or other lawful process by another party in the dispute. Efforts will be made to tell you about the request.

To a coroner or medical examiner: To authorize federal officials in service to protect the President, other heads of state, or conduct special investigations.

To the institution or official if you are an inmate of a correctional institution or under custody of law enforcement officials.

To a law enforcement official in response to a court subpoena, warrant summons, or other lawful process, to identify a suspect, fugitive, witness, or missing person, about a victim, criminal conduct or criminal death. For emergency circumstances concerning crime information.

If you are a member of the armed forces as required by military command authorities.

Your Rights Concerning Privacy of your Protected Health Information: Individuals seeking treatment have the right to request that we restrict our uses and disclosures of their PHI. We are not obliged to agree to those restrictions, but if we do, we must abide by them. Therefore, restrictions to consent will not be granted without the express permission of the Medical Director and/or Health Services Administrator who will evaluate an individual's request and determine:

1) if the restrictions are reasonable and
2) if it is possible to implement the restriction in our practice

Should the request be granted, the consent form will reflect the restrictions allowed.

Your request must tell us what information you want to limit, whether you want to limit use or disclosure or both and who you want the limits to apply to. Your request must be made in writing.

Breach Notification Requirements. It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

Questions and Complaints:

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to the Office Manager. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. We supportyour right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US:

Sulzbacher Health Center
Sulzbacher Village

5455 Springfield Blvd.
Jacksonville, Florida 32208
(904) 394-4958

Wolfson Children's Health Center

3701 Winton Dr.
Jacksonville, Florida 32208
(904) 924-1624

SULZBACHER VILLAGE
PEDIATRIC HEALTH CENTER

UNIVERSAL PATIENT AUTHORIZATION FORM FOR FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND QUALITY OF CARE

****PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW****

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): _____

Date of Birth (mm/dd/yyyy):_____

Address: _____City: _____ State: _____ Zip:_____

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure:

OF WHAT: ALL MY HEALTH INFORMATION including any information about sensitive conditions (if any) [See page 2 for details]

FROM WHOM: ALL information sources [See page 2 for details]

TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name: **Village Pediatric Health Center** Phone: **(904) 394-4958**

Address: **5455 Springfield Blvd, Jacksonville, Florida 32208** Fax: **(904) 453-7200**

PURPOSE: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission.

REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read all pages of this form and agree to the disclosures above from the types of sources listed.**

X

Signature of Patient or Patient's Legal Representative Date Signed (mm/dd/yyyy)

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ☐ Parent of minor
- ☐ Guardian
- ☐ Other personal representative (explain: _____)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

Explanation of Form Florida AHCA FC4200-004
"Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"Of What": includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. **All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:**
    a. Drug, alcohol, or substance abuse
    b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
    c. Sickle cell anemia
    d. Birth control and family planning
    e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
    f. Genetic (inherited) diseases or tests
2. **Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.**
3. **Information created before or after the date of this form.**

"From Whom" includes: **All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom": For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

"Purpose": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

"Revocation": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses by giving written notice. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re-disclosure of Information": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.

SULZBACHER VILLAGE
PEDIATRIC HEALTH CENTER

PATIENT CONSENT FOR PELVIC EXAMINATION

A Pelvic Examination is an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum or external pelvic tissue or organs. This procedure is used to diagnose and /or treat conditions that involve the pelvis. It may be performed using any combination of modalities, which may include the health care provider's gloved hand or instrumentation.

By signing this consent, I _____ authorize and direct Sulzbacher and my treating healthcare provider, the employed and/or contracted medical personnel of Sulzbacher as deemed necessary by my treating physician, and the medical students and/or students receiving training as a health care provider who may be involved in my care, to perform a pelvic examination as described above. I understand that a pelvic examination may be needed while receiving medical care from Sulzbacher in the future, and I hereby agree and acknowledge that this written consent applies to any and all pelvic examinations conducted today, or in the future, by a health care provider, medical student, or student receiving training as a health care provider employed by and/or contracted with Sulzbacher unless I revoke this consent in writing by hand delivering a copy of the revocation to Sulzbacher. By my signature below acknowledge that I have read or have read to me and understand the contents of this form.

Patient/Legal Representative Signature

_____ _____

Witness Signature **Printed Name and Date**

_____ _____

Physician/Provider Signature **Printed Name and Date**

_____ _____

Implementation July 1, 2020, F.S. Section 456.51

SULZBACHER VILLAGE
PEDIATRIC HEALTH CENTER

COVID-19 HEALTH SCREENING FORM

Screening and Evaluation for Patients at Sulzbacher Village Pediatric Clinic as of March 16, 2020

PRINT PATIENT NAME:_____ **PATIENT D.O.B.:**_____

Symptom Screening

PLEASE READ EACH QUESTION CAREFULLY

Do you have a fever and/or symptoms of acute respiratory illness such as cough, sore throat, difficulty breathing?

O Yes O No

Have you had contact in the last 14 days (about 2 weeks) with a person who tested positive for COVID-19, is currently being tested, or has been placed on home quarantine by the department of health?

O Yes O No

If the caregiver of the patient answers "YES" to any of the screening questions or have ANY symptoms, they will be given a mask that covers their mouth and nose. (If someone is with the patient, give them a mask as well).

If one (1) or more answers is "YES", then give patients a mask that covers their mouth and nose. (If someone is with the patient, give them a mask as well).

If all answers are "NO," then the patient can be checked in for his or her appointment.

SULZBACHER VILLAGE
PEDIATRIC HEALTH CENTER

TELEHEALTH CONSENT FORM

DATE: _____

PRINT PATIENT NAME: _____

- I hereby authorize Sulzbacher Village Pediatric Clinic to use the telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical condition.
- I understand that technical difficulties may occur before or during the telehe alth sessions and my appointment cannot be started or ended as intended.
- I accept that professionals can contact interactive session with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.
- I understand that if I have insurance, the telehealth visit(s) may be billed; however, I will not be billed if insurance does not cover the cost.
- I agree that my medical records on telehealth can be kept for further evaluation, analysis, and documentation, and in all of these, my information will be kept private.

Parent/Guardian Signature: _____ Date: _____

Print Parent/Guardian: _____

Verbal Consent:

In the event, that the patient is accessing Telehealth services from their home or other location, and is otherwise unable to sign this consent form, provider has explained and discussed the benefits and shortcomings of receiving Telehealth services and the patient has verbally consented to receiving Telehealth services.

Provider Signature: _____ Date: _____