CLSC
COMPLETE LOCAL SPECIALTY CARE

NEW PATIENT FORM

PERSONAL INFORMATION			
Last Name		First Name	
First Name Used		Middle Name	
Former Last Name		Date of Birth	
Social Security No.		Legal Sex	
Gender Identity	☐ Male ☐Female ☐Transgender FTM ☐ Transgedner MTF ☐ Gender non-conforming ☐ Choose not to disclose ☐Other, please specify _____	Assigned Sex at Birth	☐ Male ☐ Female ☐ Choose not to disclose ☐ Unknown
Preferred Pronouns	☐he/him ☐ she/her ☐they/them	Sexual Orientation	☐ Homosexual ☐ Heterosexual ☐ Bisexual ☐Do not know ☐ Choose not to describe
Address			
City		State + Zip Code	
Cell Phone		Home Phone	
Work Phone		Email Address	
Preferred Method of Contact	☐ Cell Phone ☐ Home Phone ☐ Email ☐ Text Message	Marital Status	
Employer		Student Status	☐ Full time ☐Part time ☐Not a Student

INSURANCE INFORMATION			
Primary Ins.		Ins. ID	

BOCA RATON (561) 391-8086
950 Glades Rd Suite 4A
Boca Raton, FL 33431

COCONUT CREEK (954) 570-9595
5355 Lyons Rd
Coconut Creek, FL 33073

HALLANDALE (954) 458-2572
2500 E Hallandale Beach Blvd Suite 301
Hallandale Beach, FL 33009

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Secondary Ins.		Ins. ID	

RACE, ETHNICITY, LANGUAGE INFORMATION

Language		Translator ?	☐ YES ☐ NO
Race	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic ☐ White ☐ Bi-racial ☐ Other Race ☐ unreported/refuse to answer	Ethnicity	☐ No, not Hispanic/Latino ☐ Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race.)

RESPONSIBLE PARTY (If other than self)

Last Name		First Name	
Middle Name		Date of Birth	
Sex	☐ Male ☐ Female	Relationship	

EMERGENCY CONTACT

Last Name		First Name	
Middle Name		Date of Birth	
Phone Number		Relationship	
Address			

PHARMACY INFORMATION

Name			
Phone Number		Address	

PATIENT NAME			
DATE OF BIRTH		TODAY'S DATE	

PAYMENT OF BENEFITS

I authorize payments as determined by CLSC, directly to CLSC. I understand that I may still be responsible for any amounts not paid by my insurance company. For further details, I will consult the CLSC Financial Policy. (_____)

MEDICAL RELEASE AUTHORIZATION

I authorize any insurance company, organization, employer, hospital physician, dentist or pharmacist to release any information requested with regards to processing my claims. I certify that the information I provide is true and correct. I know and understand that it is a crime to fill out this form with facts that I know are false and/or to leave out facts that I know are important. (_____)

PRESCRIPTION MEDICATION HISTORY CONSENT

By signing this consent form, I agree to allowing CLSC to request and use my prescription medication history from other healthcare providers and/or a third party pharmacy benefit payers for treatment purposes. (_____)

Understanding all of the above, I hereby provide informed consent to CLSC to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

PATIENT SIGNATURE	
DATE	

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MEDICAL RECORD AUTHORIZATION

Fax: (954) 354 - 8151

Patient Name	
Date of Birth	
Phone Number	

I hereby authorize CLSC to: _____ Obtain From _____ Release To

Doctor/Hospital			
Address			
Phone Number		**Fax**	

____ All medical records and/or information including those portions, if any, pertaining to HIV Testing, AIDS Diagnosis or treatment, Drug or Alcohol Abuse and treatment, or Psychiatric treatment.

____ Specific Records Listed: _____

_____

I understand that the medical records are confidential and cannot be disclosed without specific written consent of the person to whom they pertain or permitted by law. I further understand that once released, the record custodian, or its employees have no responsibility of liability that may arise regarding any suspect of this authorization.

I agree to accept responsibility for payment of any charges for the information requested. I understand fee charges are within the allowable by Florida Law. The copying fee is waived only when copies are for continuing medical care.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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ADVANCE DIRECTIVES

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

Please indicate below any Health Care Advance Directives you have.

I, _____, have created the following Advance Directives.

_____ Living Will

_____ Health Care Surrogate Designation

_____ Anatomical Donation

_____ Other (please specify): _____

Please sign below to acknowledge that you have read and understand this information.

PATIENT NAME			
DATE OF BIRTH		TODAY'S DATE	
PATIENT SIGNATURE			

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NOTICE OF PRIVACY PRACTICES

I, _____, have been informed of Complete Local Specialty Care's ("CLSC") health information privacy policies, as outlined below, and understand that a copy of CLSC's ***NOTICE OF PRIVACY PRACTICE*** is posted in the waiting room. A copy of this notice will be provided to me upon my request.

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rule, outlined below. A federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) along with a brief overview of our Notice of Privacy. Our practice strives to comply with HIPPA's regulations.

WHAT IS HIPPA AND HOW DOES THE PRIVACY RULE AFFECT ME? When the Health Insurance Portability and Accountability Act (HIPPA) was passed in August of 1996 this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to be compliant with this regulation, as of April 14, 2003. Under the Privacy Rule, you are guaranteed access to your medical records, allowed control over how protected health information is used and disclosed, and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

WHAT IS INDIVIDUALLY HEALTH INFORMATION (IIHI)? Any health information you provide our practice, including your mailing address. Information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payments, and/or identifies you as an individual.

WHAT IS THE NOTICE OF PRIVACY PRACTICE? Our practice has the official ***NOTICE OF PRIVACY PRACTICE*** posted in our waiting room informing our patients about their rights surrounding the protection of your IIHI and our obligations concerning the use and disclosure of your IIHI.

If you have any questions regarding this notice and our health information privacy practices, please contact the office manager(s).

I have read the short notice provided by CLSC's practice and have been informed of how to obtain more information regarding our Notice of Privacy.

PATIENT NAME			
DATE OF BIRTH		TODAY'S DATE	
PATIENT SIGNATURE			

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NOTICE OF PRIVACY PRACTICES

INFORMED CONSENT: I authorize medical treatment as deemed necessary and appropriate by the physicians/nurse practitioners/ and or Physician Assistants of CLSC and their employees participating in my care. I will provide all necessary information related to my healthcare needs that may affect the treatment I may receive, including but not limited to; past medical history, past and current medications, and current medical issues. I understand that if I do not provide all necessary information pertaining to my current health, that I will not hold the providers or other employees of CLSC liable for any adverse reactions.

With my consent, CLSC, may use and disclose Protected Health Information (PHI), about me to carry out treatment, payment and healthcare operations. Please refer to the CLSC Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, CLSC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment or healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and diagnostic results.

With my consent, CLSC may contact me via Email and/or SMS for patient satisfaction/experience purposes. (_____)

NOTICE OF DISCLAIMER: This shall serve as notice that not all medical services are available or performed at CLSC Clinics. Services that are deemed necessary for the treatment or diagnosis of the patient and determined by our Providers as necessary or in the best interest of the management of the patient's condition and any services that may be required at other specialized facilities outside of any CLSC Clinic locations are not part of or billed from CLSC.

Any emergency care that the attending physician or mid-level provider believes should, in the best interest of the patient, be provided by another Facility, will not be the financial responsibility of CLSC. A referral to another specialty service or facility will be done in the best interest of the patient and CLSC. CLSC has no financial interest in referral facilities or specialist referrals.

Patients must agree to see a specialist physician when a medical problem is outside the scope of general medical care or for pre-existing conditions requiring a specialist as determined by our providers.

My signature below indicates that I have read and understand the above informed consent and disclaimer, and I am consenting to treatment at CLSC.

PATIENT NAME			
DATE OF BIRTH			
PATIENT SIGNATURE			

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AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

It is our policy to **NOT** release confidential and/or unauthorized information except appointment confirmation by home telephone answering machine, work telephone, voicemail, cell phone, and/or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an authorized person who may answer the phone.

With that in mind, many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you would like to have information released to someone other than yourself, please complete the following:

I authorize CLSC clinics to release my medical and/or billing information to the following individuals:

NAME	RELATION TO PATIENT	PHONE NUMBER

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

PATIENT NAME			
DATE OF BIRTH		TODAY'S DATE	
PATIENT SIGNATURE			