FLAGLER FREE CLINIC

Patient Needs Survey

Where would you seek healthcare if not at Flagler Free Clinic?

_____

Have you been hospitalized in the last 12 months? _____Yes_____Where_____No

If yes, Reason_____

Have you been to the Emergency Room in the last 12 months?_____Yes_____Where_____No

Reason_____

Have you been seen at Azalea Clinic in the last 12 months?_____Yes_____No

When did you last see a primary care provider?_____

Providers Name:_____

What is the highest level of education that you have completed?

Elementary (K-8)_____
High School (9-12)_____
GED_____

College or University
2 year_____
4 year_____
Post graduate_____

Are you a registered voter?_____Yes_____No

How many people live in your household?_____List all adults & children below and their relationship to you.

Name	Relationship to you	Age

Are you employed? _____Yes_____No

If Yes, Name & Location of Employer_____

If No, how long have you been unemployed?_____

Are you seeking employment?_____Yes_____No

Employable Skills_____

FLAGLER COUNTY FREE CLINIC

What county do you live in?

_____Flagler _____Volusia _____St John's _____Duval Other (specify)_____

Are you here to get treatment due to an injury at work or are you here to get treatment due to a car or motorcycle accident?

_____No _____Yes

If you are involved in a Workman's Compensation claim, motor vehicle accident or "slip and fall" injury, you have insurance related to that claim, accident or injury and we will not treat you for any medical issues related to those types of accidents.

Are you here to get a prescription for a narcotic or any other controlled substance for pain?

_____No _____Yes

We do not prescribe narcotics here. These include valium, xanax, lortab, hydrocodone, percocet, dilaudid, clonopin, ambient, lunesta, soma, restoril, ativan, darvocet, morphine etc.

Are you here because of depression, Anxiety issues or other mental health Issues such as bi-polar disorder?

_____No _____Yes

We will discuss your condition, however, we may have to refer you to a mental health specialist, as we do not treat mental health issues.

Are you seeking disability?

_____No _____Yes

We do not perform any of the in-depth tests, analysis, studies or procedures that are needed to document a disability. We do not provide medical records to any disability agency or attorney unless a subpoena Is issued.

Do you have medical or insurance (including from another state).

_____No _____Yes

If Yes, please indicate type of insurance below:

_____Medicare _____Medicaid

_____Medicaid Share of Cost _____Private Insurance

Are you currently under the care of another medical doctor?

_____No _____Yes

If so, please explain why you are seeking our medical care.

PLEASE SIGN HERE:_____DATE:_____

Patient Acknowledgment of Receipt of Notice of Privacy Practices

Please Print

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

_____

_____

_____

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature:_____ Date: ____/____/____

Name: _____
Please Print

Relationship to Patient: _____

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

☐ Patient refused to sign (date of refusal) ____/____/____.

☐ Communications barriers prohibited obtaining an acknowledgment.

☐ An emergency situation prevented us from obtaining an acknowledgment.

☐ Other _____

Attempt was made by:_____ Date: ____/____/____

Patient Consent & Authorization for Release of Protected Health Information

Please Print

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP Code: _____ Telephone Number: _____

E-mail Address: _____

Patient Authorization

I, _____, hereby authorize the release, use or disclosure of my health information as follows:

This authorization pertains to the following type of medical information about me:

_____

_____

I hereby authorize _____
Name of individual(s) and/or organization providing information

to release the above-described information to _____.
Name of individual(s) and/or organization receiving this information

I understand that, per my request, this authorization will permit the above-named parties to use or disclose the identified health information for purposes beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that I may revoke this authorization at any time by providing written notification to:

_____.

The revocation will be effective on the date it has been received and processed by the above-named recipient. I understand that the revocation does not apply to actions taken in reliance upon this authorization prior to the effective date of revocation. I also understand that I do not have to sign this authorization in order to receive treatment, payment, or to enroll or be eligible for benefits.

Unless I request in writing otherwise, I understand that this authorization will expire on _____. If I do not
Expiration date or event
specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient, and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

Patient or Personal Representative

Signature: _____ Date: ___/___/___

Name: _____
Please Print

Relationship to Patient: _____

For Office Use Only

Received by: _____ Date: ___/___/___

Patient's Bill of Rights and Responsibilities

Section 381.026, Florida Statutes, addresses the Patient's Bill of Rights and Responsibilities. The purpose of this section is to promote the interests and well being of patients and to promote better communication between the patient and the health care provider. Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. An abridged summary of your rights and responsibilities follows.

A patient has the right to:

- Be treated with courtesy and respect, with appreciation of his or her dignity, and with protection of privacy.
- Receive a prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for his or her care.
- Know what patient support services are available, including if an interpreter is available if the patient does not speak English.
- Know what rules and regulations apply to his or her conduct.
- Be given by the health care provider information such as diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Refuse any treatment, except as otherwise provided by law.
- Be given full information and necessary counseling on the availability of known financial resources for care.
- Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- Express complaints regarding any violation of his or her rights.

A patient is responsible for:

- Giving the health care provider accurate information about present complaints, past illnesses, hospitalizations, medications, and any other information about his or her health.
- Reporting unexpected changes in his or her condition to the health care provider.
- Reporting to the health care provider whether he or she understands a planned course of action and what is expected of him or her.
- Following the treatment plan recommended by the health care provider.
- Keeping appointments and, when unable to do so, notifying the health care provider or facility.
- His or her actions if treatment is refused or if the patient does not follow the health care provider’s instructions.
- Making sure financial responsibilities are carried out.
- Following health care facility conduct rules and regulations.

PATIENT”S SIGNATURE

DATE