Date: ___/___/____

Langley Health Services

Patient Information- Page 1

Legal Name: (Last)	(First)	(Middle Initial)
Legal Sex (sex assigned at birth): ☐ Female ☐ Male		**Date of Birth:** Month/Day/Year ______/______/______
Social Security Number: _ _ _ - _ _ - _ _ _ _	**Email Address:**	
Home Phone: (_ _ _) _ _ _ - _ _ _ _	**Cell Phone:** (_ _ _) _ _ _ - _ _ _ _	**Best Number to Use:** ☐ Home ☐ Cell ☐ Work
		Best Time to Call: ☐ AM ☐ Afternoon ☐ PM

Ways We Can Communicate With You: ☐ Voice (phone) ☐ Text (phone) ☐ Portal ☐ Email

Mailing Address: (Street) (City) (State) (Zip Code)

Emergency Contact Name:	**Emergency Contact Number:**

Marital Status
☐ Divorced
☐ Married
☐ Partner
☐ Single
☐ Unknown
☐ Widowed
☐ Legally separated
☐ Other:________________

Preferred Language (choose one):
☐ English
☐ Español
☐ Other:

____

Racial Group(s) *check all that apply*
☐ African American/Black
☐ Asian
☐ Caucasian/White
☐ Native American/Alaskan Native
☐ Pacific Islander
☐ Other:

____

Ethnicity
☐ Hispanic/Latino(a)
☐ Not Hispanic/Latino(a)

Employment Status
☐ Employed full-time
☐ Employed part-time
☐ Unemployed
☐ Self-employed
☐ Retired
☐ Active duty
☐ Reserved for national assignment
☐ Unknown

What is your annual income?
☐ $1-$27,000
☐ $27,001 - $33,000
☐ $33,001 - $40,000
☐ $40,001+
☐ No income

1a. How many people (including you) does your income support?

____

Do you think of yourself as:
☐ Lesbian, gay, or homosexual
☐ Straight or heterosexual
☐ Bisexual
☐ Do not know
☐ Choose not to disclose

What is your gender?
☐ Male
☐ Female
☐ Female-to-male transgender
☐ Male-to-female transgender
☐ Genderqueer or not exclusively male or female
☐ Choose not to disclose

Which describes your housing situation (choose one):
☐ Own/Rent
☐ Live with friend/doubling up
☐ Street/Car
☐ Shelter
☐ Transitional
☐ Other: _____________

Veteran Status
☐ Veteran
☐ Not a Veteran

Migrant/Seasonal Farm Workers (in the past 2 years):
Have you, or head of household, worked in agricultural labor?
☐ Yes ☐ No
Did you, or head of household, move from this area to another county or state in search of agricultural work?
☐ Yes ☐ No
Has your family earned more than half their income from seasonal agriculture?
☐ Yes ☐ No

Pharmacy Name:	**Pharmacy Address/Phone #:**
Lab Name:	

TURN OVER TO PAGE 2

Patient Information- Page 2

Responsible Party Information

(Person financially responsible for patient's account)

If same as above, go to insurance information section

Legal Name: (Last)	(First)	(Middle Initial)	**Date of Birth:** Month/Day/Year ______/______/______
Home Phone: (_ _ _) _ _ _ - _ _ _ _	**Cell Phone:** (_ _ _) _ _ _ - _ _ _ _	**Work Phone:** (_ _ _) _ _ _ - _ _ _ _	**Social Security Number:** __ __ __ - __ __ - __ __ __ __
Street Address: (Street)	(City)	(State)	(Zip Code)
Mailing Address: (Street)	(City)	(State)	(Zip Code)

Insurance Information

Primary Insurance Company

Insurance Company Name:		
Address: (Street) (City) (State) (Zip Code)		
ID #:	**Group #:**	**Employer Name:**
Name of Insured:	**Date of Birth of Insured:** Month/Day/Year ______/______/______	**Social Security Number of Insured:** __ __ __ - __ __ - __ __ __ __
Mailing Address of Insured: (Street) (City) (State) (Zip Code)		
Home Phone of Insured: (_ _ _) _ _ _ - _ _ _ _	**Cell Phone of Insured:** (_ _ _) _ _ _ - _ _ _ _	**Work Phone of Insured:** (_ _ _) _ _ _ - _ _ _ _
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other		

Secondary Insurance Company

Insurance Company Name:		
Address: (Street) (City) (State) (Zip Code)		
ID #:	**Group #:**	**Employer Name:**
Name of Insured:	**Date of Birth of Insured:** Month/Day/Year ______/______/______	**Social Security Number of Insured:** __ __ __ - __ __ - __ __ __ __
Mailing Address of Insured: (Street) (City) (State) (Zip Code)		
Home Phone of Insured: (_ _ _) _ _ _ - _ _ _ _	**Cell Phone of Insured:** (_ _ _) _ _ _ - _ _ _ _	**Work Phone of Insured:** (_ _ _) _ _ _ - _ _ _ _
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other		

Patient Consents and Acknowledgements

PATIENT NAME: ___________________________ DATE OF BIRTH: ___________________________

	INITIAL
I. Consent for Treatment I hereby give consent and authorize examination and treatment at Project Health, Inc. d/b/a Langley Health Services (LHS) for myself, the patient, by the personnel at LHS. The need for the examination and treatment, and the possibility of undesirable side effects, will be explained by the employees of LHS. I understand there is no guarantee or assurance, as to the results which may be obtained, but normal prudent care will be exercised by employees or LHS concerning my diagnosis and treatment.	
II. Consent for Treatment of a Minor ***only complete if patient is under 18 years of age*** I, as the parent or legal guardian of the patient, _________________________, do hereby give my consent and authorize treatment. Furthermore, I grant permission for the following individuals to authorize Medical Treatment in my absence: 1. ____ **Relationship to patient:**_________________________ 2. ____ **Relationship to patient:**_________________________ 3. ____ **Relationship to patient:**_________________________	
III. Patient Rights & Responsibilities, Notice of Privacy Practices, and Patient Centered Medical Home These documents are posted in the lobby and provided in this packet. I acknowledge that I have also received a copy.	
IV. Residents and Students I understand that Project Health, Inc. d/b/a Langley Health Services supports the education of medical professionals and maintains Residents and Students that may assist in relation to care.	
V. Notice of Policy Regarding Advanced Directives (for patients over 18 years of age) Advanced Directives are legal statements that indicate the type of medical treatment wanted or not wanted in the event an individual is unable to make decisions as well as who is authorized to make them. Advance directives are made and witnessed prior to serious injury. In accordance with federal and state law, this serves as notification that we will set aside your advance directive in the event you experience a life threatening event while at one of the Langley Health Services locations and you will be transferred to a higher level of care. By signing below, you agree and understand this as notification. Please indicate below whether or not you have an advanced directive or if you would like to receive information on advance directives. ☐ I have an advanced directive. ☐ I do not have an advanced directive. ☐ I would like to receive information on advanced directives.	
VI. Notice Regarding Appointments Your appointment time is time set aside for YOU to meet with your provider. The amount of time set aside was based on your needs. • You are expected to arrive 15 minutes before your appointment. Every effort will be made to see you on time. If you are more than 10 minutes late, your provider may not be able to see you. You may then be seen in the Walk-In Clinic, or by another provider, depending on the urgency of your need and available time. • If you cannot keep your appointment, it is important to let us know 24-48 hours in advance. We can then use the time to serve someone else. This makes good use of your provider's time and makes it easier for everyone to get an appointment when they need it. • If you miss your appointment, your prescription may not be refilled until you come in for your next appointment.	
VII. Release of Information • Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions or for any other purpose related to benefit payment. • If I am covered by Medicaid or Medicare, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, drug and alcohol treatment and discharge summary. • Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes	

as may be permitted by law. I understand that this facility may be a member of such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases such as HIV and AIDS.
I hereby permit the practice and the physicians or other health professionals involved in my care to release healthcare information for purposes of treatment, payment, and/or healthcare operations.

VIII. Consent for Use and Disclosure of Protected Health Information (PHI)
Project Health, Inc. d/b/a Langley Health Services (LHS) is committed to ensuring the privacy and confidentiality of your medical information. To assist us in protecting your privacy, please complete the following information:

(Check Yes or No)	Yes	No
May we leave a clinical message if no answer?		
May we leave a billing concern message if no answer?		
May we send an appointment reminder using text messaging? *If yes, what is your cell phone carrier?* _______________________________		
May we send you an email regarding reminders and clinical notes?		

May we leave information with someone other than you regarding your medical care (medication changes, laboratory results, appointments, etc? ☐ Yes (If yes, please list the name(s) in the space(s) below, ☐ No

Name	Relationship	Phone Number

**You have the right to revoke whom we talk with about your health care at anytime. Please complete a new consent.

X. Assignment of Medicare Benefit ***(ONLY FOR PATIENTS COVERED BY MEDICARE)***
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment or authorized benefits be made on my behalf. I assign the benefits payable for physician services or authorize such physician or organization to submit a claim to Medicare and request payment of medical insurance benefits to the party who accepts assignment. I permit a copy of this authorization to be used in place of the original, as long as I receive services at LHS. I understand that I am responsible for my co-insurance amount on Medicare coverable services. I further understand that the Part B deductible does not apply to FQHC services; however, should I receive services that are non-covered under FQHC, I will be responsible for the part B deductible. I have completed a copy of the Medicare Secondary Payor (MSP) Questionnaire.

____ ____
Signature of Patient or Parent/Guardian Signature of Witness

_______________________________________ ____
Printed name of Patient or Parent/Guardian Printed Name of Witness

____ ____
Date Date

The next 3 pages are for you (the patient) to keep for your personal information.

Notice of Privacy Practices
Effective September 30, 2013

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How we may use and disclose health care information about you:

- **For Care or Treatment**: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. ***Example:*** *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*
- **For Payment:** Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*
- **For Business Operations:** We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Example:*** *We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*
- **Required by Law:** Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.
- **Without Authorization**: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:
    - Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
    - Required by Court Order
    - Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- **Verbal Permission:** We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.
- **With Authorization**: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

Your rights regarding your PHI

- You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Website Privacy

Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site.

Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches:

You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at *LHS.* If you have questions and would like additional information, you may contact us at (352) 793-5900 or toll free at (888) 298-5510.

PATIENT RIGHTS

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know that rules and regulations apply to his or her conduct.
- A patient has the right to know to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- A patient has the right to pain relief.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate licensing agency.
- A patient has the right to change providers if other qualified providers are available.
- A patient has a right to have his or her prescriptions filled at their pharmacy of choice.
- A patient has the right to information and an explanation regarding the Patient Centered Medical Home approach to care.
- A patient has the right to obtain information and forms related to Advanced Directives (living will and health care surrogate designation).

PATIENT RESPONSIBILITIES

- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her care.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible to provide a responsible adult to provide transportation home and to remain with patient as directed by the provider or as indicated on discharge instructions.
- A patient is responsible for keeping appointments and, when unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatments or does not follow the provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct toward all health care professionals and staff, as well as other patients and visitors.
- If participating in the Patient Centered Medical Home, a patient is responsible for talking with his/her team about health questions, sharing past health care successes and challenges, telling the team about other health care professionals that care for him/her, following the health care plan that has been discussed, making sure he/she understands the plan and asks questions if not understanding, telling the team if you are having trouble sticking with the care plan, and speaking up if the care plan is not working so together changes can be made, if needed.

Revised 8/15/2018

Patient Name: ______________________
Date of Birth: ______________________

Medical History Form (please give this completed form to your Nurse or Medical Assistant)

Allergies (medications, foods, or plants): ______________________________________

Past Medical History *(please check the box(es) that apply to you)*:

Alcoholism /Drug Use	Asthma	Cancer	COPD	Diabetes	Heart Disease	High Cholesterol	High blood pressure	Kidney disease	Mental illness	Migraines	Stroke	Thyroid Disease	Other
		Type:											If so, please list here: ________________________________ ________________________________

Surgical History *(if no history, please leave blank; if yes, please specify type and date of surgery below)*:

Type:	**Date:**

Social History *(please check the box next to those that apply to you)*:

	YES	NO		YES	NO
Current smoker? *If yes, how many packs/day?*			Alcohol use *If yes, how many drinks/day?*		
Former smoker? *If yes, how long has it been since you last smoked?*			Drug use *If yes, what kind?*		
Other tobacco use? *If yes, what type?*			Sleep *How many hours/day?*		
Caffeine *How many cups/day?*			Exercise *How many times/week?*		

FOR FEMALE PATIENTS ONLY- OB/GYN History *(please check the box next to those that apply to you)*:

	YES	NO		YES	NO
History of STD? *If yes, what type?*			Currently pregnant		
			Total Number of Pregnancies		
Last Menstrual Period:			Total Number of Deliveries		

Family History *(please check the box next to those that apply to you)*:

	Alcoholism /Drug Use	Asthma	Cancer	COPD	Diabetes	Heart Disease	High Cholesterol	High blood pressure	Kidney disease	Mental illness	Migraines	Stroke	Thyroid Disease	Other
Mother														
Father														
Brother														
Sister														
Child														
Maternal GM														
Maternal GF														
Paternal GM														
Paternal GF														

Mother's Health Status: ALIVE: Age _____ DECEASED: Age _____ Father's Health Status: ALIVE: Age _______ DECEASED: Age _______