

New Patient Intake Information:

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

SSN: _____ Date of Birth: _____ Mobile Phone: _____

Email: _____

Gender ☐ Male ☐ Female Ethnicity: ☐ Hispanic/Latino/Spanish ☐ Non-Hispanic/Latino ☐ Chose not to Disclose	Gender Identity: ☐ Male ☐ Female ☐ Transgender M to F ☐ Transgender F to M ☐ Other ☐ Don't want to Disclose
Race (Circle): ☐ Asian ☐ American Indian ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Don't want to Disclose	Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Don't Know ☐ Chose not to Disclose

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Partner

Preferred Language: _____

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Contact Phone Number: _____

Insurance Company Name: _____ Subscriber Name: _____

Insurance ID #: _____ Insurance Group Number: _____

Insurance Address: _____

Insurance Phone Number: _____ Subscriber SSN: _____ Subscriber DOB: _____

Additional Insurance Name: _____ Subscriber Name: _____

Insurance ID #: _____ Insurance Group Number: _____

Insurance Address: _____

Insurance Phone Number: _____ Subscriber SSN: _____ Subscriber DOB: _____

Preferred Pharmacy: _____ Address: _____ Phone: _____

CCRH Pharmacy will be listed as your preferred pharmacy if no pharmacy information is provided

Employer: _____ Employer Phone: _____ Occupation: _____

Agricultural Worker: ☐ No ☐ Yes Type: ☐ Migratory ☐ Seasonal ☐ Chose Not to Disclose

Migratory – within 24 months of your visit, you have left the community to work elsewhere

Seasonal – within 24 months of your visit, you are/were paid to work piecework, hourly, daily wages in a season

Homeless Status: ☐ No ☐ Yes Type: ☐ Chose not to Disclose

☐ Homeless Shelter – Live in an organized shelter for homeless persons	☐ Transitional Housing – live in a small unit that helps to transition from homelessness to permanent housing
☐ Doubling Up – live with other individuals in their home/apartment	☐ Street – live outdoors (car, encampment, makeshift housing)
☐ Permanent Supportive Housing – live in a housing unit that provides community-based support and resources	☐ Other – live in a single room occupancy, motel, hotel, day to day paid housing

Veteran Status: No Yes Chose not to Disclose

Public Housing: No Yes Chose not to Disclose

Patient/Parent/Legal Guardian Name (Print)

Patient/Parent/Legal Guardian Name (Signature)

Date

NEW PATIENT QUESTIONNAIRE

Name: _____ DOB: _____ Date: _____

What is the main reason you are seeing the provider today?

Allergies: _____

Medications: Please include name of medication and dose as well as list vitamins/supplements and OTC

Surgical History:

Please list all providers you see AND their specialty (Dermatology, Endocrinology, Cardiology, Urology, etc.)

Have you been diagnosed with any of the following?

High Blood Pressure ☐	High Cholesterol ☐	Diabetes ☐	Thyroid Disorder ☐	Cancer ☐
Frequent Urinary Tract Infections ☐	Kidney Problems ☐	Neuropathy ☐	Acid Reflux ☐	Asthma/ COPD ☐
Sleep Apnea ☐	Insomnia ☐	Anxiety/ Depression ☐	Arthritis ☐	Heart Problems ☐

Other medical conditions:

When was the last time you had health screenings for the following?

Colonoscopy _____

Mammogram _____

Blood Work _____

Pap Smear _____

Other: _____

Discount Schedule Eligibility Worksheet

Name: Date of Birth: SSN:

You must provide proof of income to qualify for the discount schedule. This information must be updated at least annually, and anytime your household income size and/ or medical insurance status changes. You will be responsible for the full amount of the visit and the discount will not be applied to your account until you give CCRH the required proof of income. If proof of income is given to us within 30 days of the visit, and if you are eligible, the discount will be applied retroactively, and all following visits will be discounted.

List your name and the names of ALL individuals who lives with you. Name, Relationship, Age, Gender, Date of Birth, Annual Income, Employer, or Self-Employed. If you need more space, please continue on the back of this form.

(List your name and the names of ALL individuals who lives with you)

Name	Relationship	Age	Gender	DoB	Annual Income	Employer

			Yes	No
Are you currently employed?			☐	☐
Do you work seasonally only?			☐	☐
How much money do you and all who live in your household bring in per:	Week	Month	Year	
	\$	\$	\$	
If you are not working , how are you meeting your monthly expenses? Please check an option			Savings	Borrowing
			☐	☐
			Other	
			☐	
			Yes	No
Do you have health insurance? If yes, what is the deductible amount? \$			☐	☐
Do you have Medicaid?			☐	☐
Did you apply?			☐	☐
Were you denied Medicaid Insurance?			☐	☐
Do you have Medicare?			☐	☐
Are you eligible to apply?			☐	☐

List **ALL** that you, and those living in your household receive:

(Amount per month/year Salary or wages)

\$	Unemployment	\$	Public Assistance (ATAP)
\$	Social Security	\$	Permanent Fund
\$	Pension/Retirement	\$	Longevity Bonus
\$	Rental Income/Dividends	\$	Self-Employed (Net Amount)
\$	Interests	\$	Worker's Comp Benefits
\$	Spousal Support	\$	Disability Benefits
\$	Child Support	\$	Other
\$	Foster Care	\$	Total Monthly/Annual Household Income

PLEASE READ AND SIGN

I authorize all government agencies, employers and any companies, agencies, or persons listed herein to provide information about me to Citrus County Rural Health, Inc. Health Center (CCRH), the State of Florida, and/or the federal government. I also authorize CCRH to disclose this information to agencies, third party payers and other health care providers as necessary to qualify me for reduced fees. I certify that the statements regarding the persons and income in my household are true and correct to the best of my knowledge. I further understand if any information is found to be inaccurate, I may be denied a discount and/or subject to legal action for knowingly providing false information. I agree to notify CCRH of all changes in income, address, living arrangements, number of household members, and/or other circumstances. I understand that the information given above will be kept confidential except for the purposes noted above and not be release without my written permission. I also understand that if I do not agree with any decision made concerning this application, I have the right to ask in writing for a review by the CEO of Citrus County Rural Health, Inc.

Signature: _____ Date: _____

FOR OFFICE USE ONLY			
Total Annual Income:		# of Family Members	
Verified By:		Date:	
Verified with: ☐ Pay Stubs ☐ Tax Forms ☐ EVF ☐ CVF ☐ Other			
Proof Returned Date:		Discount Effective Date:	
Qualified?: ☐ Yes ☐ No		Discount%: ☐ 100% ☐ 75% ☐ 50% ☐ 25%	
Requalify Date:			



CONSENT TO TREAT

Patient Printed Name: (Last, First)

Date of Birth

I, the undersigned, voluntarily give consent to my Citrus County Rural Health, Inc (CCRH) medical professional(s) to perform the evaluation necessary to establish my plan of care, provide and perform such medical/diagnostic/minor surgical treatment(s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I will have the opportunity to discuss and ask questions about the purpose, potentials risks, benefits, and alternatives for anything that is ordered to ensure I can make an informed decision, which includes the ability to refuse part or all of the treatment plan. I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. This consent will remain in effect until it is revoked in writing. I understand that I may occasionally be asked to sign a new consent, and that if invasive or interventional procedures are recommended, I may be asked to read and sign additional consent forms for such procedures.

I also understand and consent to the collection of specimens (pap smear, biopsy, culture, urine, blood work, etc.) in order for the medical provider to properly diagnose and treat my medical conditions or as a component of my employer's wellness incentive program. I give permission for my specimens to be sent to an CCRH contracted laboratory vendor for analysis.

CCRH participates in clinical education programs with area colleges and universities to give students engaged in a course of study related to a medical career, including nursing students, medical students, interns, and residents ("students") experience in clinical practice. Your provider has agreed to permit such students to observe and participate in his/her patient care activities.

_____By initialing here, you agree to permit the students working in your provider's office to observe and participate in your medical care during your appointment. You agree that you have been given the opportunity to refuse to give such consent and that you may withdraw your consent at any time during your appointment.

_____By initialing here, you acknowledge that exercise may be recommended as a part of one of CCRH's wellness programs. Patient participation in the exercise component of the programs is entirely at their own risk. CCRH is not to be held liable for any adverse effect resulting from participation in exercise activities. If you have any questions or CCRH regarding participation in any specific activities, it is your responsibility to consult your medical provider(s) prior to participating in those activities.

_____ **Labs and Diagnostic Imaging:** By initialing here, you release CCRH of liability for any lab and/or diagnostic imaging testing that was ordered and not completed as recommended. You also acknowledge that failure to follow through with recommended testing in a timely manner may result in delayed or missed diagnosis that may have a significant or even detrimental negative impact on your health outcome. If you do not intend to follow through with the recommended diagnostic workup, it is your responsibility to inform your provider so that this may be documented in your medical record accordingly and an alternative clinical approach may be considered.

_____ **Referrals:** Over the course of treatment, you may be provided with a referral for further evaluation or treatment. It is the patient's responsibility to schedule the appointment with the outside entity, to ensure the appointment is kept along with any recommended follow-up visits or testing, and to ensure CCRH has received all results and records. CCRH requires a follow-up appointment to discuss the outcome of any consultations. Failure to follow through with any part of this process may result in significant and even detrimental negative health outcomes. If you do not intend to follow through with any part of this process, it is your responsibility to communicate this to your CCRH provider to allow for documentation of your decision in the medical record and to consider an alternative clinical approach. By initialing here, you release CCRH of liability for any adverse outcomes caused by the patient's failure to follow through with referrals provided as part of your treatment plan.

Signature of Patient / Legal Representative

Today's Date

REV: 12232024



Patient Printed Name: (Last, First)

Date of Birth

**RECEIPT OF NOTICE OF PRIVACY PRACTICES AND SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND
RESPONSIBILITIES WRITTEN ACKNOWLEDGMENT FORM**

I have received/reviewed a copy of the Citrus County Rural Health, Inc notice of Privacy Practices and the Summary of Florida Patient Bill of Rights.

Signature of Patient / Legal Representative

Today's Date



CONSENT TO PARTICIPATE IN THE PRISMA HEALTH INFORMATION EXCHANGE



Dear CCRH Patient,

We at CCRH are strong proponents of providing comprehensive patient care. Part of being able to do that is our provider having access to your health information. Whether you had a recent visit with a specialist or a stay in the hospital, having access to that information in a timely manner will enable our team to provide you with the best quality of care without delay. As currently there is not a universal electronic medical record system that allows visibility across the health care network, health information exchanges have been created such as **Carequality** and **CommonWell Health Alliance Networks**. Our company is now able to access these information exchanges through a service called PRISMA.

What is PRISMA?

PRISMA is a service that brings together your health records from participating small clinics to large-scale hospital systems making your health information accessible to your medical provider. There is no cost to patients to participate in this service.

How do we use the health information we acquire and share through PRISMA?

- **Better coordinate your care across different doctors** — Health information from other settings will be available for your healthcare providers here at CCRH. Information from us will also be available to your other doctors outside of CCRH. This could prove especially beneficial in an emergent situation, allowing an ER doctor to access critical health information.
 - Only healthcare staff directly involved in your care will access your medical information shared through PRISMA.
- **Support better care decision-making** — With timely access to information, your doctors may be able to make better decisions about your health.
 - This information will only be used to help improve your care and will not be shared without your permission or unless it's required by law.
- **Securely and confidentially** — Your Protected Health Information ("PHI") will always be confidential and used only to inform the PRISMA participating healthcare providers you receive care from. We will not use your PHI for discriminatory purposes of any kind or to deny medical treatment.
 - You can opt-out of this service anytime by calling or visiting this doctor's office and asking them to unenroll you from PRISMA.

I consent to participate in this program allowing CCRH to share and receive information with PRISMA in an effort to provide me with the best quality of care possible. I understand this consent will stay in effect until a request to opt out is made.

☐ Accept

☐ Decline

Patient Name (Print)

Patient Date of Birth (mm/dd/yyyy)

Patient Signature

Date

****CCRH ADMIN SECTION ONLY****

CCRH STAFF MEMBER/WITNESS:

DATE eCW PERMISSIONS GRANTED:

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY), AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to Citrus County Rural Health, Inc. as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by Citrus County Rural Health, Inc. regardless of its managed care network participation status. **I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.** I hereby authorize Citrus County Rural Health, Inc. to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to Citrus County Rural Health, Inc. any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from Citrus County Rural Health, Inc. or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to Citrus County Rural Health, Inc. any legal or administrative claim or chose an action arising under any group health plan employee benefits plan, health insurance or tort feisor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I received from Citrus County Rural Health, Inc. (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to Citrus County Rural Health, Inc. all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by Citrus County Rural Health, Inc. including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (Citrus County Rural Health Inc) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

Date of signature



PATIENT REFERRAL ACKNOWLEDGEMENT

Citrus County Rural Health (CCRH)

In the case that a **CCRH provider recommends** that you receive further evaluation and treatment from an **outside provider/specialist**. **You acknowledge and agree with the following:**

1. CCRH will require a follow-up appointment with a CCRH provider to discuss the outcome of your consultation and to ensure the referral was completed.
2. If you do not wish to go to the outside provider/specialist you are referred to by CCRH (or if no specific provider was specified in the referral), you may go to an outside provider/specialist of your choosing. It is recommended that you select an outside provider/specialist within your insurance health plan network.
3. It will be your responsibility to schedule the appointment with the outside provider/specialist and ensure the appointment is kept.
4. It will be your responsibility to inform CCRH of your appointment with the specialist and request that the specialist office forward ALL consultation notes and records BACK to the CCRH provider.
5. Failure to follow through with referral as recommended may result in significant negative health outcomes.
6. CCRH will not be liable for any such negative outcomes caused by a patient's failure to follow through with the recommended course of treatment, which in this case would involve evaluation and treatment by an outside provider.
7. If you need to speak to a health center team member about your referral, please call 352-565-7342.

Patient Name (Print): _____

Patient Signature: _____

Date: _____



CITRUS COUNTY RURAL HEALTH
927 N CITRUS AVE,
CRYSTAL RIVER, FL, 34428
PH: (352)565-7342
FX: (877)673-1688

Authorization To Release or Receive Protected Health Information

I hereby authorize Citrus County Rural Health to release or receive medical, psychiatric, psychological or social service information from my/my child's records. The release of alcohol and drug testing/history, STD or HIV testing/history, genetic testing, and psychotherapy notes is prohibited unless I specifically authorize below.

Citrus County Rural Health Inc is authorized to ☐ RELEASE or ☐ RECEIVE the following information as requested:

Medical (Circle)

All Medical Records ☐

Specific Date of Service: ☐

Immunization Records ☐

STD/HIV Records ☐

Genetic Testing ☐

Drug Records ☐

Alcohol Records ☐

Other: _____

Psychiatric/Psychological Evaluation ☐

Verbal/Written Progress Notes ☐

Assessment/Testing Information ☐

Case Summary/Updates ☐

Treatment Plan ☐

Diagnosis/Evaluation ☐

Discharge Summary ☐

To/From the following Provider or

Person: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Fax: _____

I understand I may revoke this authorization at any time by completing a "Revocation of Authorization" form (can be obtained from the Privacy Officer). I understand that revoking my/my child's records does not apply to records that have been disclosed previously. If not revoked, this authorization will terminate on the date that I or my child is no longer a patient of Citrus County Rural Health.

Patient Name (Printed)

Date of Birth

Today's Date

Patient/Legal Guardian Signature

Relationship to Patient

CCRH Witness



**CONSENT FOR DISCLOSURE OF PROTECTED HEALTH
INFORMATION TO FAMILY MEMBER/FRIEND**

If you wish to allow CITRUS COUNTY RURAL HEALTH to disclose protected health information about you to a family member(s) or other person(s) involved in your care please complete this form and sign where indicated.

Patient Printed Name: (Last, First)

Date of Birth

I consent to disclosure of the following protected health information about me to the following individual(s):

NAME OF FAMILY MEMBER/FRIEND RELATIONSHIP TO PATIENT

CONTACT INFORMATION

Protected health information to be disclosed (CHECK ONE):

☐ Disclose all of my protected health information (including but not limited to diagnoses, lab and test results, prognosis, treatment for all conditions)

☐ Disclose all of my protected health information EXCEPT THE FOLLOWING (check as applicable):

☐ Mental health records

☐ Communicable diseases (including HIV/AIDS)

☐ Alcohol/drug abuse treatment

☐ Other (specify): _____

☐ Disclose ONLY the following protected health information (SPECIFY): _____

My consent will remain in effect until I notify CITRUS COUNTY RURAL HEALTH **in writing** of any changes. I understand that I may revoke this consent, **in writing**, at any time, except where CITRUS COUNTY RURAL HEALTH has already made disclosures in reliance on it.

Signature of Patient/Legal Representative

Today's Date