Florida Department of Health in Gulf County

2475 Garrison Avenue • Port St Joe, FL 32456• (850) 227-1276 • FAX (850) 227-1794
807 Highway 22 • Wewahitchka, FL 32465• (850) 639-2644 • FAX (850) 639-5934

FINANCIAL STATEMENT FOR FEE DETERMINATION

Name:_____ Birthdate:_____ Soc. Sec. Number:_____
Mailing Address:_____ City:_____ State:_____
Street Address:_____ City:_____ State:_____
Work Phone Number:_____ Home Phone Number:_____
Cell Phone Number:_____ Race (if multi-racial, please list):_____
Marital Status:_____ Veteran's Discharged: _____ Yes or _____ No
Ethnicity (check one): Hispanic_____ Non-Hispanic _____ Primary Language: _____
Do you have any cultural and/or religious beliefs that could affect your treatment? ____ Yes or ____ No
(If yes, please discuss with provider)

**********PLEASE READ CAREFULLY REGARDING YOUR FEE FOR SERVICES********

The Florida Department of Health in Gulf County offers a **sliding fee scale**. If you choose to answer questions regarding your income, it will be used solely for sliding fee scale determination and you will be charged a fee for our services based on your family size and annual income. Please provide the below information to assist in determining your fee. You may request a review of the fee charge. You have the right to refuse to give financial information, thereby accepting a fee equal to the full cost of service.

I choose to pay full cost of service. Yes ____ No ____
Are you on Medicaid, Medicare, or private insurance? Yes ___ No ___
Name of Primary Insurance:_____ Name of Secondary Insurance:_____
Name of Dental Insurance: _____

INCOME FOR YOUR COMPLETE HOUSEHOLD OR FAMILY UNIT
List each family member in household and include **ALL** types of income (SSI, AFDC, child support, retirement, unemployment, etc.)

NAME	DATE OF BIRTH	FAMILY RELATION	PLACE OF EMPLOYMENT OR OTHER SOURCE OF INCOME	INCOME BEFORE DEDUCTION OR TAXES (PLEASE CIRCLE)
1.				$ WK MO
2.				$ WK MO
3.				$ WK MO
4.				$ WK MO
5.				$ WK MO

Do you pay out child care or support? Yes _____ No _____ How much monthly? _____

PLEASE READ CAREFULLY BEFORE SIGNING: I certify that the above information is true and correct to the best of my knowledge and belief. I know that I may be prosecuted under state law if I knowingly conceal or report wrong information. I give consent to the staff of the Florida Department of Health in Gulf County to make inquiry and verify the information I have reported. I agree to report any change in gross income in excess of fifty dollars ($50) per month and any change in number of dependents. If I knowingly withhold or falsely misrepresent any information, I will be assessed at full cost of service.

Signature:_____ **Date**: _____

CONTACT PERSON IN CASE OF EMERGENCY:
Name of contact:_____ Relation:_____
Phone number of contact person: Home:_____ Work:_____

Patient History Form

Name_____**Age**_____

Date of Last Physical Exam_____Physician_____

Please List ALL medications & dose taken presently, including over the counter and herbal medications:_____

_____

_____

_____

*Please answer the following questions by checking the appropriate box. (**Y**=Yes, **N**=No).*

	Y	**N**
1. Are you under any medical treatment now?		
2. Do you have any medication allergies? (if yes, **please list**)		
3. Have you had any recent/past surgeries? (if yes, please explain)		
4. Heart problems		
5. Family history of heart problems		
6. High Cholesterol		
7. High blood pressure		
8. Respiratory Disease		
9. Rheumatic Fever		
10. Diabetes		
11. Family history of diabetes		
12. Blood diseases		
13. Liver diseases (Hepatitis, Jaundice)		
14. Kidney diseases		
15. Stomach or Intestinal diseases		
16. Sexually transmitted diseases		
17. Any risk for HIV infection		
18. Have you ever been diagnosed with cancer?		
19. Seizure disorder		
20. Have you ever had a serious head injury?		
21. Mental or emotional health problems?		
22. History of domestic violence		
23. Do you use Tobacco products? (if yes, please explain) Type of Tobacco_____How many per day_____		
24. Any alcohol/drug use? (if yes, please explain) Type_____How many per day _____		
25. Any weight loss or gain?		
26. Are you on a diet?		
27. Do you have a preference for religious/cultural beliefs that may affect your treatment? (if yes, please explain)		
28. For **Pediatric** patients: Are childhood shots up to date?		
*For Females Only:		
29. Are you or could you be pregnant?		
30. Have you had a Hysterectomy? If yes, When:_____		
31. Last menstrual cycle: _____		
32. Last pap smear: _____		
33. Last mammogram: _____		

Signature_____**Date**_____

Relationship to Minor if applicable_____ *Revised 11/09*

Reviewed by MD/PA/ARNP_____

BROKEN APPOINTMENT & NO SHOW POLICY

Florida Department of Health in Gulf County strives to service and improve the health of our patients. For us to be able to better serve and be more efficient for our patients we have established a Broken Appointment and No Show Policy.

Due to increasing number of broken appointments at the FDOH Gulf County and dental clinic sites, it is necessary to enforce a Broken Appointment/No Show Policy effective immediately.

It is the responsibility of the patient (or parent, in the case of a child) to notify the FDOH Gulf County or dental clinic at least 24 hours prior to their scheduled appointment if they will be unable to make their appointment. Appointments cancelled at least 3 hours before scheduled appointment will not be considered a No Show. If there are three or more No Shows or broken appointments without proper notice, the patient will not be offered pre-booked appointments for up to one year. The patient will be offered to come in and wait to be seen as a work in.

Every effort will be made to contact patients by phone or mail to remind them of their appointment a few days before it is scheduled. Monday appointments will be contacted on the Friday prior due to weekend closure. It is the responsibility of the patient to notify FDOH Gulf County or dental clinic of current contact information for this purpose.

By signing below, you acknowledge that you have read and understand the above statement and that every effort will be made to contact the FDOH Gulf County or dental clinics when you are unable to keep your appointment.

Signature: _____ Date: _____

Witness: _____ Date: _____

INITIATION OF SERVICES

PART I CLIENT-PROVIDER RELATIONSHIP CONSENT

Client Name: _____

Name of Agency: Florida Department of Health in Gulf County

Agency Address: 2475 Garrison Avenue, Port St Joe, FL 32456/ 807 Hwy 22, Wewahitchka, FL 32465

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical office visits including obtaining medical history, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue the relationship at any time.

PART II DISCLOSURE OF INFORMATION CONSENT (treatment, payment or healthcare operations purposes only**)**

I consent to the use and disclosure of my medical information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations.

PART III MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my medical information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above named agency and authorize it to submit a claim to Medicare for payment.

PART IV ASSIGNMENT OF BENEFITS (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS

_____ Client/Representative Signature

_____ Self or Representative's Relationship to Client

_____ Date

_____ Witness (optional)

_____ Date

PART VI WITHDRAWAL OF CONSENT

I, _____ WITHDRAW THIS CONSENT, effective _____

Client/Representative Signature — Date

_____ Witness (optional)

_____ Date

Client Name: _____

ID#: _____

DOB: _____