

PATIENT
INSURED PARTY

Last Name _____ Company _____
 First Name _____ Policy No. _____
 Email Address _____ Group No. _____
 Florida Tech Mailbox Number _____ Policy Holder _____
 Address _____ Policy Holder DOB _____
 City _____ Phone _____
 State _____ ZIP _____
 Cell or Home Phone _____
 Student ID/SSN _____
 Employer _____
 Work Phone _____
 Date of Birth _____
 Emergency Contact Name _____ Phone _____
 Primary Care Physician _____

Race: White American or Alaska Native Asian Black or African American Native Hawaiian or other Pacific Islander Other
 Ethnicity: Non Hispanic Hispanic or Latino
 Marital Status: Single Married Separated Divorced Widowed

Consent for Treatment: The undersigned authorizes the Florida Tech O.A. Holzer Health Center to provide treatment including X-rays, blood withdrawal, local anesthesia, intravenous solutions and the performance of which the provider considers necessary and proper in the treatment of the above named patient.

Cancellation/ No Show Policy: I, the undersigned, understand the Health Center requires a 24 hours' notice of cancellation. Patients who repeatedly cancel or do not show for their schedule appointments may lose eligibility for services and may be referred to an off-campus provider.

Release of Records: I hereby authorize the provider to furnish insurance companies with any information concerning my treatment that may be requested, including photocopies from my patient records as necessary for completion of my claim or as may be requested by law. I further authorize the provider to furnish information from my records pertaining to the treatment as requested by other doctors or medical care facilities for continued care and treatment.

Payment Agreement: I, the undersigned, understand that I am responsible for all charges for treatment received regardless of insurance coverage. I understand that the provider cannot accept responsibility for collecting any insurance claim or negotiating any settlement on a disputed claim. Provider reserves the right to decline further services to the patient for non-payment. Patient accounts are due at the time treatment is given unless other arrangements are made in advance. A charge of \$27.50 will be charged on all RETURNED CHECKS.

I, the undersigned, assign benefits payable for physician services to the physician or organization furnishing the services and authorize the physician group/organization to submit a claim to my health insurance carrier on my behalf.

Signature of patient (or parent, if a minor) _____ Date _____



HOLZER STUDENT HEALTH CENTER POLICY

I understand that any procedures, in-clinic testing, laboratory/blood work or X-rays will be billed to my personal health insurance. This includes in-clinic testing for urinary tract infections, strep throat, pregnancy, influenza and mononucleosis. I am financially responsible for any medical services not covered by my health insurance. I acknowledge that the insurance information I have provided is accurate and complete to the best of my knowledge.

I understand it is my responsibility to know the coverage and limitations of my own insurance, whether it is through my parents or the university.

Signature _____ Date _____

UNITED HEALTHCARE—STUDENT RESOURCES (STUDENT HEALTH INSURANCE PARTICIPANTS)

Your insurance requires a deductible each academic year (i.e., patient is responsible for the first \$75 of medical expenses). Please call United Healthcare insurance company for more information or access uhcsr.com for Florida Tech student health insurance information.

Signature _____ Date _____

Your Florida Tech student health insurance representative can be reached at 321-674-8080. We encourage you to consult your student medical plan for further information regarding coverage and exclusions before calling. A student health insurance booklet is available online.



Name _____ Birth Date _____

List of current medications

Allergies to medications _____

List previous surgeries/hospitalizations _____

Have you had a history of any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Eye Problems |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Stomach/Bowel Problems |
| <input type="checkbox"/> Skin Problems | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Asthma/Lung Problems |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Gall Bladder Disease |
| <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> STDs | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Bulimia |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |

Additional concerns _____

Have you ever been treated for mental illness or emotional problems? Yes No

Do you use Tobacco? Yes No Alcohol? Yes No Drugs? Yes No

Has anyone hit you or struck you in the last 18 months? Yes No

Are there any diseases that run in your family? Yes No If yes, please list _____



Consent to the Use and Disclosure of Health Information for Treatment, Payment or Health Operations

I, _____ (*patient name*), understand that as part of my health care, this practice originated and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatments and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to use or disclosure of my health information _____

I fully understand and accept decline the terms of this consent.

Signature of patient or legal representative _____ Date _____



I request the following alternatives or limitations relating to communications directed to me by my health care provider or employee of PREMIER PRIMARY CARE.

Do we have your permission to call you at home or at the number you have given? Yes No

If yes, may we leave the following information on your answering machine or voice mail?

Appointment Information Yes No

Billing Information Yes No

Medical Information Yes No

May we contact you by email? Yes No

If yes, may we provide the following information on your email?

Appointment Information Yes No

Billing Information Yes No

Medical Information Yes No

***Please Note: Emails sent over the internet are not necessarily secure. Florida Tech Holzer Health Center cannot guarantee the confidentiality or security of any information sent over the internet when using email. The Florida Tech Holzer Health Center shall not be liable for any breach of confidentiality resulting from such use of email.**

I give my permission to share the following information with the person(s) named below:

Name _____ Relationship _____
Appointment: Yes No Billing: Yes No Medical: Yes No

Name _____ Relationship _____
Appointment: Yes No Billing: Yes No Medical: Yes No

Name _____ Relationship _____
Appointment: Yes No Billing: Yes No Medical: Yes No

Name _____ Relationship _____
Appointment: Yes No Billing: Yes No Medical: Yes No

Patient Signature _____ Date _____

