Palms Medical Group

Your home for health, wellness, life

Welcome!

Thank you for allowing us the opportunity to become your new medical home. Palms Medical Group is a community health center designed to meet your individual needs, as well as the needs of your entire family. We offer a wide range of services, from sick visits to chronic disease management, pharmacy services to chiropractic care, dental to behavioral health care. We are confident that we have you covered. Our focus is to provide you with complete preventive health care designed to keep you healthy. A dedicated provider or provider team, of your choice, along with a highly qualified team of nurses and staff will build a relationship with you to meet all of your healthcare needs. Welcome to the family!

As always, we can be reached for any questions at our toll free number 1-888-730-2374. If you have any concerns or complaints you would like to share, please call (352) 463-4503.

For your convenience, after our offices close, we provide access to an after-hours nurse on call. This nurse can be reached at (352) 264-2202. If you are having a medical emergency, please call 911.

Please help us understand how we can better serve you by completing the enclosed quality improvement survey.

Mission Statement

To improve health, wellness, and life by providing a compassionate medical home, while promoting training and education. Our focus is on meeting patient needs efficiently and effectively, without regard for the paient's ability to render payment.

Your home for health, wellness and life.

All Information is Required and Confidential Date:_________

PATIENT REGISTRATION INFORMATION

LAST Name:___________________________**FIRST:** _______________________________________ **MI:** _______

Date of Birth: ________________________ **Social Security Number:** ___________________________

Mailing Address: _______________________________________ **Apt. #** _______________

City: ___________________________ **State:** ____________________ **Zip:** ____________

Sex: ❑ **Female** ❑ **Male** **Marital Status:** ❑ **Single** ❑ **Married** ❑ **Other**

Home Phone Number: (______)____________________ **Work Phone: (_________)________________**

Preferred Language: ___________________ **Are you a full time student?** ❑ **Yes** ❑ **No**

Please list your preferred Primary Care Provider at our Clinic: ______________________________

Email address: _______________________________________

(Providing your email will allow you access to your healthcare information online once you sign up for our Patient Portal)

Race: ❑ **Black/African American** ❑ **White/Caucasian** ❑ **American Indian/Alaska Native** ❑ **Asian**
❑ **Pacific Islander** ❑ **Native Hawaiian** ❑ **Other** ❑ **Multi**

Approximate Household Income*: $_____________ ❑ **Weekly** ❑ **Monthly** ❑ **Annually**

Number of People in Household: __________

Head of Household: ________________________________ **Date of Birth:** ______________________

*****This is strictly confidential information and is used solely for Palms Medical Group benefit.**

Ethnicity Identity Only: Hispanic/Latino ❑ **Yes** ❑ **No** **Veteran:** ❑ **Yes** ❑ **No**

Migrant Worker ❑ **Yes** ❑ **No** Seasonal Worker ❑ **Yes** ❑ **No**

Do you have a language barrier? ❑ **Yes** ❑ **No**

Are you Homeless: ❑ **Yes** ❑ **No** **If "yes" please specify: Doubled Up _____ Shelter ______**

Public Housing: ❑ **Yes** ❑ **No** **Street ______ Transitional ________ Other ________**

IF PATIENT HAS A GUARDIAN LIST GUARDIAN INFORMATION HERE

LAST NAME: __________________________ **FIRST:** _________________________ **SS#:**__________________

Mailing Address: ____**Date of Birth:**_________

Relationship to the Patient: ______________________________ **Driver's License #:** _______________________

Home PH# (__________)_____________________________ **Work PH#: (_______)** _______________________

Person to Notify in an Emergency: **Name:** ________________________________ **Phone:**________________

I wish to be contacted in the following manner

Home telephone: ____________________________ | Work telephone: ____________________________

☐ OK to leave message with detailed info
☐ Leave message with call back number only

☐ OK to leave message with detailed info
☐ Leave message with call back number only

Is it ok to mail to address listed on file? ☐ Yes ☐ No

Communication to Family and Others involved in your care

Please list any family members of others who may be involved in coordinating your care. Also, please indicate what kind of information may be shared with each individual. **(If patient is a minor please list both parent names below)**

Name	Relationship to Patient	Type of Information: All	Appoint-meant	Medical	Bill/Payment

How did you hear about Palms Medical Group? (Mark all that apply):

__________ **Telephone Book (*name of book*)** ____________________________________ __**Insurance Primary Care Physician**
__________ **Newspaper (*name of newspaper*)** ___________________________________ **(*name of ins. plan*):** _____________
__________ **Patient Referral (*name and DOB of patient that referred you*)** ____________ __ **Other Advertising**
__________ **Physician Referral (*name of physicians that referred you*)** __ **Internet**

Revised October 2015

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Designated Individuals Authorization Form

I wish to be contacted in the following manner (check all that apply)	
Home telephone ___________________ ❑ OK to leave message with detailed information. ❑ Leave message with call back number only.	Work telephone __________________________ ❑ OK to leave message with detailed information. ❑ Leave message with call back number only.
Written Communication ❑ OK to mail to my home address. ❑ OK to mail to this address:____	

Communication with Family and Others involved in your care

Please list any family members or others who may be involved in coordinating your care. Also, please indicate what kind of information may be shared with each individual. **Note: Individuals not on this form will not be allowed to receive any information about your care.**

		Type of Information			
Name	Relationship to Patient	All	Appointment	Medical	Billing/Payment

I understand that I may cancel this designation at any time by signing the revocation section below. I understand that any cancellation can only apply to future disclosures and cannot cancel actions taken or disclosures made while the designation was in effect.

Patient's Signature	Date:
Witness Signature	Date:

Revocation Section

I hereby cancel this authorization for designated individuals to have access to my protected health information.

Signature:____ Date: ______________________________

Board Approved 03/19/2015

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PATIENT CONSENTS AND ACKNOWLEDGMENTS

I. Consent for the Use and Disclosure of Protected Health Information for Payment, Treatment or Healthcare Operations

I understand that as part of my health care, Palms Medical Group originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment, any plans for my 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 diagnostic information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- 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 copy of Palms Medical Group **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to inspect and copy health information used to make decisions regarding my care,
- The right to amend my health information if I feel Palms Medical Group has incomplete or incorrect information,
- The right to an accounting of disclosure of my health information,
- The right to request restrictions regarding my health information,
- Right to request confidential communications regarding my health information

I understand that Palms Medical Group is not required to agree to the restrictions requested, if it is not possible for us to ensure our compliance or believe it will negatively impact the care we may provide you.

I understand and accept the terms of this consent.

II. Consent for Treatment

I authorize Palms Medical Group staff to provide medical and/or dental treatment including any necessary procedures required in the course of diagnosis and treatment, and of such treatment as necessary.

III. Insurance Assignment

I hereby assign to Palms Medical Group my right to the insurance benefits that may be payable for services provided, arising from any insurance policy, in my name, or in my behalf. I authorize payment of benefits directly to Palms Medical Group; I understand that this assignment of benefits does not relieve me from responsibility for the balance on my account for services that may not be covered by Insurance, Medicare or Medicaid.

IV. Designated Individuals Communication Consent

I give permission for my Protected Health Information to be disclosed for purposes of coordinating health care needs, communicating results, findings and care decisions to the friends and/or family members I have listed on my **Patient Registration Form**.

I understand that I may cancel this designation at any time. I understand that any cancellation can only apply to future disclosures and cannot cancel actions taken or disclosures made while the designation was in effect.

Signature	Witness