Dear New Patient,

Welcome! Thank you for choosing Archer Family Health Care, a health care service of the UF College of Nursing. Attached is the patient packet. We ask that you complete all pages thoroughly and bring it with you to your visit. If you take any prescribed or over-the-counter medication, please bring your bottle(s), even if empty, with you. You will need to arrive 30 minutes early to allow enough time to meet with the Financial Assistant Counselor prior to your appointment.

We are located at 16939 SW 134th Avenue in downtown Archer. If you are traveling on State Road 27/45 north bound turn left at 134th Ave; if you are traveling south bound turn right. Continue approximately 2/10th of a mile. We are located on the left side of 134th Ave.

We strive to see our patients on time and appreciate your promptness. If your wait is longer than 20 minutes, please notify the person at the front desk. A 24 hour cancellation notice is required. However, if circumstances arise and you need to change your appointment time, please give as much notice as possible to allow someone else to be scheduled in the time reserved for you.

Please bring your photo identification and insurance information with you. We will bill your insurance company. However, you will be responsible for non-covered services, out-of-network services, deductibles, coinsurances, and/or co-payments.

If you are applying for the Reduced Payment Program, verification of your financial status and total household income is needed to determine your co-pay. If the required information is not provided, you will be charged the full fee for services rendered.

Payment is due at the time service is rendered. We accept cash, debit and credit cards.

You can visit our website at http://afhc.nursing.ufl.edu to learn more about Archer Family Health Care.

Thank you for choosing our health care team.

Meet Our Team:
ARNPs: Denise Schentrup, DNP, ARNP, Clinic Director; Ashley Kairalla MSN, ARNP; Danielle Dodd MSN, ARNP; Susan Shaffer, PhD, ARNP; Karen Rye, MSN, ARNP-MH; Stacia Hayes, MSN, ARNP; Lou Hillebrand, CMW
Consulting Physician David Feller, MD
Clinical Pharmacist James Taylor Pharm, D; Karen Whalen, Pharm, D, BCPS, CDE
Practice Manager Joan N. Walker, CMM, CPM
Clinical Support Staff
Chikako Alvarado, LPN
Sarai Torres, LPN

Administrative Staff
Phyllis Stephens, Financial Assistance Counselor
Dawn Alexander, CPB Clinical Service Representative II
Ana Ortiz, Clinical Service Representative I
Gillian Eagle, RN, CDC, Case Manager
Tom E. Metcalfe Jr., MBA Business System Builder

The Foundation for The Gator Nation
An Equal Opportunity Institution
Patient Responsibility Policy

Proof of Income
1. Uninsured patients, who wish to be considered for care at a reduced cost, must provide proof of total household income each year. If proof of income is not provided on the first visit, the patient will be reminded by the Office Staff to bring this to the next visit. If proof is not provided at the time of the second visit future appointments will not be scheduled until such proof is submitted to the practice. As a reminder that proof of income is still needed, the Office Manager will send a letter to the patient requesting such information. If information is still not provided, urgent care will be provided for a period of 30 days and the patient will receive a letter of discharge from the practice.

2. Payment is Due at time Services are Rendered
Per the contract agreement between patients and insurance carriers, co-pays, deductible and any non-covered services are due at the time services are rendered. If a patient does not have health insurance, the quoted fee provided by the Office Staff is due at the time of service as well. We accept personal checks or cash.

3. Payment Arrangement for Balance Due
If a patient wishes to establish a payment plan instead of paying in full for services rendered, the patient must request to speak with the Office Manager. The Office Manager will determine an appropriate payment plan based upon the patients income. The Patient and the Office Manager will agree upon the payment amount and date the payment is due in accordance with the payment plan or payments each month. It is the patient’s responsibility to make contact with the Office Manager to discuss any unforeseen situations that might prevent timely payments.

The Office Manager will contact patients who have past due balances by the 20th of each month as a reminder of the past due amount. If after 3 consecutive months there is no payment activity from the patient, the patient will be notified that Archer Family Health Care will provide only urgent care for a period of 30 days until the patient meets with the Office Manager to establish a new payment plan.

4. Appointment Cancellations
Cancellation of an appointment or rescheduling of an appointment requires at least 24-hours notice.
5. **No Show**
A “no show” occurs when a patient fails to cancel or reschedule an appointment with at least 24-hours notice. If a patient accumulates 3 “no shows” the patient will receive a letter of discharge from the practice, which dismisses you from the practice for a period of one year. If at the end of one year the patient desires to come back to the practice the patient will be accepted as a new patient.
If a patient fails to cancel or reschedule two appointments with proper notice, a letter will be sent explaining how requests for future appointments will be handled.

6. **Adherence to Treatment**
Health Care is a partnership between the Patient and Healthcare Provider. It is the Provider’s responsibility to discuss options for care and to recommend preferred plan of care to each patient. It is the patients’ responsibility to adhere to the agreed upon plan of care. If a patient does not adhere to the plan of care after discussion with the provider, the provider may discharge the patient from the practice.

I have read the above Patient Responsibilities and agree to abide to the terms

___________________________________  __________________
Patient or Guardians Signature  Date

___________________________________  ________________
Name  DOB
SECTION A: NOTICE OF LIMITED LIABILITY

I, on behalf of myself, my child(en) and/or my ward, hereby acknowledge I have been informed that: Health care and treatment that I/we receive at Archer Family Health Care will be provided by University of Florida employees and/or agents, including but not limited to nurse practitioners, nurse-midwives, nurses and students, clinical pharmacists, and physicians, ("health care providers"). I understand these health care providers are under the exclusive supervision and control of the University of Florida Board of Trustees and liability for their acts or omissions is limited to $100,000 per claim or judgment by any one person and to $200,000 for all claims or judgments arising out of the same incident or occurrence (see Florida Statutes 768.28).

I further acknowledge that University of Florida health care providers are neither the employees nor agents of Shands Teaching Hospital and Clinics, Inc.

SECTION B: TREATMENT AUTHORIZATION, ASSIGNMENTS OF PROCEEDS, AUTHORIZATION TO RELEASE INFORMATION AND GUARANTOR AGREEMENT

I. Authorization for Routine Diagnostic Procedures and Medical Treatment – I hereby consent to such diagnostic procedures, hospital care, and medical treatment which in the judgment of my health care provider may be considered necessary or advisable while a patient at Archer Family Health Care. I recognize that Archer Family Health Care providers are employees of a health care teaching and research institution and that my treatment and care will be observed and in some instances aided by students under appropriate supervision. I consent to Archer Family Health Care taking photographs of me in the course of and related to my treatment and to their use of such photographs and my medical data for educational purposes. I hereby authorize Archer Family Health Care to retain, preserve and use for scientific, educational or research purposes, or dispose of as they might deem fit, any specimens or tissues taken from my body during hospital or clinic visits.

II. Assignment of Benefits – I hereby assign to Archer Family Health Care payment from all third party payors* with whom I have coverage or from whom benefits are or may become payable to me, for the charges of hospital and health care services I receive for, related to, or connected with this admission or treatment (past, present, or future). I agree to be personally responsible for payment of any hospital or health care services that are not covered by my third party payors*, including, but not limited to, non-covered or out-of-network services, deductibles, co-insurances, and/or co-payments.

III. Release of Medical Information by Archer Family Health Care – By signing in the space below as Patient/Guardian, I hereby authorize Archer Family Health Care providers providing services during my outpatient clinical care, to release information from and/or copies of my medical records (including information relating to psychiatric and/or psychological care, alcohol and/or substance abuse, and HIV tests), and other information as may be required for my medical care and to secure payment for charges incurred by me or on my behalf, to: any University of Florida facility or affiliated provider, the Tumor Registry, my health care provider, referring provider, the Guarantor on my accounts, insurance companies for which I have assigned benefits for my treatment and care, or to any sponsor that Archer Family Health Care may later obtain to contribute payment for my treatment and care. I also authorize release of any information to any and all regulatory and/or accrediting organizations as necessary to maintain licensure and accredited status.

In addition, I authorize release of any information to county, state or federal public health agencies, as required by law. I further authorize the Department of Children and Family Services and/or the Social Security Administration to release any confidential case information to my application for government assistance, which is requested by Archer Family Health Care.

IV. Guarantor Agreement – By signing in the space below as Patient/Guardian or Guarantor, or as Patient’s/Guardian’s Spouse or Guarantor’s Spouse, I hereby agree that all charges connected with the treatment, not covered by any insurance, program, sponsorship or other third party coverage I may have, are due and payable by me at the time of the visit or discontinuation of treatment. If the insurance information I have provided is not active at the time of service or if the services provided are not covered by my insurance company, I will be responsible for any balance due at the time of service. The charges I agree to pay are those listed in the current Fee Schedule, which is available for inspection upon request. I hereby acknowledge that, unless Archer Family Health Care and my insurance company or third party carrier have agreed that I will not be billed, if Archer Family Health Care has agreed to bill my insurance or other third party carrier it has agreed to do so as a courtesy and that Archer Family Health Care has a right to demand payment in full from me at any time, even if full payment from any insurance carrier. If an overdue account is referred by collections, I agree to pay the attorney’s fees, court costs and/or collection agency fees associated with the collection process. I specifically waive any exemption of wages from garnishment, which might be available by law, and agree that my wages can be garnished in the event a Judgment is entered against me for collection of the outpatient clinic charges I have agreed to pay.

V. Lien on Third Party Liability Proceeds – If any admission or treatment is due to an accident or injury, Archer Family Health Care shall have a lien upon the proceeds of any cause of action, suit, claim, counterclaim, or demand accruing to me or to my legal representative as a result of such accident or injury, in order to recover payment for all charges of hospital and health care services I receive for, related to, or connected with such accident or injury (past, present, or future), effective as of the date treatment was first provided. The foregoing shall be sufficient notice to me of the existence of a lien, which shall be effective whether or not it is filed in the public records. The foregoing is in addition to any lien to which Archer Family Health Care may be entitled by law.

VI. Agreement to Pay for Professional Component and Other Pathology Services – When a specimen of my blood, urine, stool, or similar materials is tested, the testing will be performed under the supervision of the pathologist who directs the laboratory. The pathologist may not perform the test or personally review its results. However, the pathologist is responsible for supervising the laboratory to assure that the results of all my tests are clinically reliable and are reported to my health care provider in a timely manner. I will receive a bill from the pathologist for these supervisory services for each test even if the pathologist did not personally perform the test or review its results. By signing this agreement, I agree to be responsible for the pathologist’s bill to the extent that my insurer or managed care plan does not pay for it.

* Third party payors include, but are not limited to, coverage available from: Medicare, Medicaid, or governmental programs; health, accident, automobile, or other insurance; worker’s compensation; HMO (commercial, Medicaid, Medicare); self-insured employers; and any sponsors who may contribute payment for services.

Patient/Guardian: _____________________________ Patient’s/Guardian’s Spouse: _____________________________

Insured (If other than patient) _____________________________ Insured (If other than patient) _____________________________

Guarantor (If other than patient/guardian) _____________________________ Guarantor’s Spouse (If other than patient’s/guardian’s spouse) _____________________________

Witness: _____________________________ Date: _____________________________

COPIES OF THIS STATEMENT SHALL BE AS VALID AS THE ORIGINAL/ORIGINAL SIGNATURES ON FILE WITH ARCHER FAMILY HEALTH CARE

11/20/07

WHITE – PATIENT  YELLOW – ARCHER FAMILY HEALTH CARE
This is the template for Archer Family Health Care

COLLECTION AND USE OF SOCIAL SECURITY NUMBER

Your Social Security Number has been collected. It is imperative for the performance of this department’s legal duties and responsibilities.

If you have questions about the collection and use of Social Security Numbers, please visit: http://privacy.ufl.edu/SSNPrivacy.html
<table>
<thead>
<tr>
<th>ORGANIZATION</th>
<th>PURPOSE</th>
<th>STATUTORY AUTHORITY</th>
<th>MANDATED, AUTHORIZED OR BUSINESS IMPERATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic Technologies</td>
<td>State contractual obligation</td>
<td>6C1-3.020</td>
<td>Business imperative</td>
</tr>
<tr>
<td>Admissions</td>
<td>Student record management</td>
<td>Sec. 119.071(5)(a)(2)(a)(II), Fla. Stat.</td>
<td>Authorized</td>
</tr>
<tr>
<td>Baby Gators Child Development</td>
<td>DOH CCFP reimbursement</td>
<td>Sec. 383.011, Fla. Stat.</td>
<td>Authorized</td>
</tr>
<tr>
<td>Bridges</td>
<td>Identity Management (UF ID)</td>
<td>6C1-2.0031</td>
<td>Business imperative</td>
</tr>
<tr>
<td>College of Dentistry</td>
<td>Tax reporting</td>
<td>Sec. 6109, I.R.C.</td>
<td>Mandated</td>
</tr>
<tr>
<td>College of Medicine</td>
<td>Tax reporting</td>
<td>Sec. 6109, I.R.C.</td>
<td>Mandated</td>
</tr>
<tr>
<td>College of Nursing</td>
<td>Tax reporting; licensure</td>
<td>Sec. 6109, I.R.C.</td>
<td>Mandated; Authorized</td>
</tr>
<tr>
<td>College of Nursing Archer Clinic</td>
<td>Patient registration; health insurance claims or verification</td>
<td>6C1-1.300</td>
<td>Business imperative</td>
</tr>
<tr>
<td>College of Pharmacy</td>
<td>Tax reporting; student applications; education certifications</td>
<td>Sec. 6109, I.R.C.; Rule 64B16-26.203 &amp; 2032, F.A.C.</td>
<td>Mandated; Business imperative</td>
</tr>
<tr>
<td>College of Public Health &amp; Health Professions</td>
<td>Tax reporting</td>
<td>Sec. 6109, I.R.C.</td>
<td>Authorized</td>
</tr>
<tr>
<td>College of Veterinary Medicine</td>
<td>Tax reporting</td>
<td>Sec. 6109, I.R.C.</td>
<td>Mandated</td>
</tr>
<tr>
<td>Continuing Education</td>
<td>Licensure; identity management; student record management</td>
<td>Sec. 119.071(5)(a)(2)(a)(II), Fla. Stat.</td>
<td>Authorized</td>
</tr>
<tr>
<td>Faculty Practice Assoc (Dental Clinics)</td>
<td>Tax reporting; patient registration &amp; health insurance verification</td>
<td>Sec. 6109, I.R.C.; 6C1-1.300</td>
<td>Mandated; Business imperative</td>
</tr>
<tr>
<td>Health Science Center Contracts</td>
<td>Contract services &amp; management</td>
<td></td>
<td>Business imperative</td>
</tr>
<tr>
<td>Housing and Residence Education</td>
<td>Florida Prepaid Housing Program Reimbursement</td>
<td>Section 1009.98, Fla. Stat.</td>
<td>Authorized</td>
</tr>
<tr>
<td>Human Resource Services</td>
<td>Tax reporting; benefits eligibility</td>
<td>Sec. 6109, I.R.C.; 6C1-1.200</td>
<td>Mandated; Business imperative</td>
</tr>
<tr>
<td>IFAS Extension, 4-H Programs</td>
<td>FDL &amp; Background Checks</td>
<td>6C1-6.013; 6C1-3.0031</td>
<td>Business imperative</td>
</tr>
<tr>
<td>Psychology Clinic</td>
<td>Patient registration; health insurance verification; SSDI benefits</td>
<td>Sec. 119.071(5)(a)(2)(a)(II), Fla. Stat.</td>
<td>Authorized</td>
</tr>
<tr>
<td>Purchasing and Disbursements</td>
<td>Tax reporting; contracts &amp; purchases</td>
<td>26 U.S.C. 6041.; 6C1-3.020</td>
<td>Mandated; Business imperative</td>
</tr>
<tr>
<td>Registrar</td>
<td>Student record management &amp; VA benefits</td>
<td>Sec. 119.071(5)(a)(2)(a)(II), Fla. Stat.</td>
<td>Authorized</td>
</tr>
<tr>
<td>Reitz Union</td>
<td>Tax reporting</td>
<td>Sec. 6109, I.R.C.</td>
<td>Mandated</td>
</tr>
<tr>
<td>Research (Sponsored Research &amp; General Clinical Research Ctr)</td>
<td>Tax reporting</td>
<td>Sec. 6109, I.R.C.</td>
<td>Mandated</td>
</tr>
<tr>
<td>Research Affairs &amp; Compliance (RAC)</td>
<td>Tax reporting</td>
<td>Sec. 6109, I.R.C.</td>
<td>Mandated</td>
</tr>
<tr>
<td>Speech &amp; Hearing Clinics</td>
<td>Patient registration; health insurance verification</td>
<td>Sec. 119.071(5)(a)(2)(a)(II), Fla. Stat.</td>
<td>Authorized</td>
</tr>
<tr>
<td>Student Financial Affairs</td>
<td>Financial aid programs</td>
<td>PL 110-315, Sec. 483</td>
<td>Authorized</td>
</tr>
<tr>
<td>Student Health Care Center</td>
<td>Health insurance verification</td>
<td>Sec. 119.071(5)(a)(2)(a)(II), Fla. Stat.</td>
<td>Authorized</td>
</tr>
<tr>
<td>Study Abroad Services (UF International Center)</td>
<td>Florida Prepaid Tuition Reimbursement</td>
<td>Section 1009.98, Fla. Stat.</td>
<td>Authorized</td>
</tr>
<tr>
<td>UF Physicians (Medical Clinics)</td>
<td>Tax reporting; health insurance</td>
<td>Sec. 6109, I.R.C.; 6C1-1.300</td>
<td>Mandated; Business imperative</td>
</tr>
<tr>
<td>UF Proton Therapy Institute</td>
<td>Tax reporting; health insurance verification</td>
<td>Sec. 6109, I.R.C.; 6C1-1.300</td>
<td>Mandated; Business imperative</td>
</tr>
<tr>
<td>UF Jacksonville Healthcare (Medical Clinics)</td>
<td>Tax reporting; health insurance verification</td>
<td>Sec. 6109, I.R.C.; 6C1-1.300</td>
<td>Mandated; Business imperative</td>
</tr>
<tr>
<td>University Financial Services</td>
<td>Tax reporting; financial aid; collections</td>
<td>Sec. 6109, I.R.C.; 6C1-3.042; Sec. 1010.03, Fla. Stat.</td>
<td>Mandated; Authorized</td>
</tr>
<tr>
<td>Veterinary Medical Center</td>
<td>Promissory notes/credit applications</td>
<td>15 U.S.C. Sec. 1681 et seq.</td>
<td>Authorized</td>
</tr>
</tbody>
</table>
CONSENT TO OBTAIN MEDICATION HISTORY

Patient ID: __________

As a user of an electronic medical record, your Archer provider would like to include your medication history in your record. A medication history is a list of prescription medicines that we or other doctors have prescribed for you. This list is collected from several sources, including your pharmacy and your health insurance.

An accurate medication history is very important to help us treat you and to avoid potentially dangerous drug interactions. By signing this consent form you give us permission to collect, and give your pharmacy and your health insurance permission to give us information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medication to treat AIDS/HIV and medicines used to treat mental conditions, such as depression. This information will become part of your electronic medical record, should your provider feel it is important to your medical care.

This medication history is a useful guide, but it may not be complete. Some pharmacies do not make drug history available to us, and the drug history might not include over the counter medicines, supplements, or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to tell us about any errors in your medication history.

_____ I give permission for Archer Family Health Care to obtain my medication history from my pharmacy, my health insurance and my other healthcare provider.

_____ I DO NOT give permission for Archer Family Health Care to obtain my medication history from my pharmacy, my health insurance nor my other healthcare providers.

Patient’s Name ___________________________________________ Date of Birth ______________________________

_________________________________________________________ _____________________________
Signature of Patient or Guardian Relationship to Patient

_________________________________________________________ _____________________________
Employee Witness to Signature Today’s Date
Pediatric Health History Form- Initial Visit

Child’s Name ___________________________________________ Date of Birth ______ Age ______

**CHILD’S PAST MEDICAL HISTORY**

**Pregnancy/Neonatal Period**
Did the mother use any drugs or alcohol during the pregnancy? □ No □ Yes If Yes, explain______________________________

Where was your child born? ____________________________________________________________

Is the child yours by □ birth □ adoption □ stepchild □ other ________________________________

Pregnancy complications ________________________________________________________________

Was your child premature? □ No □ Yes born at _____ wks. _________________________________

Delivery □ vaginal □ C-section ___________________________________________________________

Reason for C-section ___________________________________________________________________

Delivery complications ___________________________________________________________________

Birth weight ________ Birth length ________ Any problems in newborn period ________________

**Infancy/Childhood/Adolescence**

Has your child ever been treated or diagnosed with:

□ Allergies □ Asthma or reactive airway disease □ Anemia □ Anxiety □ Bleeding disorders □ Cancer

□ Depression □ Diabetes □ Fractures or breaks □ Genetic syndrome □ GERD

□ Heart disease or heart murmur □ Kidney disease □ Migraines or headaches □ Vision or hearing problems

□ Sexually transmitted disease □ Seizures □ Sports Injuries (concussions, etc.) □ Other__________________________

Has your child ever been hospitalized □ No □ Yes, Explain: ________________________________

Previous surgeries and dates ______________________________________________________________________________________

Please list any specialists your child is currently seeing and reason: ________________________________________________

___________________________________________________________________________________________

**Medications**

ALLERGIES to medicine or vaccine (list and describe reaction) ________________________________________

___________________________________________________________________________________________

CURRENT medications and dose: __________________________________________________________________________

Vitamins/supplements/over the counter medications: __________________________________________________________________

**Development/Nutrition**

At what age did your child do the following: ______________ sit alone ______________ walk alone

____________________ speak ______________ toilet train

Was your child breastfed? □ No □ Yes, for _____ months ______________________________

Has your child had any dietary problems? __________________________________________________________

Current milk intake: Type________________________ Amount per day __________________________

**SOCIAL HISTORY**

Who lives at home with the child? □ Mom □ Dad □ Stepparent □ Siblings (# ______) □ Grandparents □ Other________________________

Child’s parents are: □ Married □ Unmarried □ Divorced □ Other: ___________________________________________

Childcare: _________________________________________________________________________________

Days per week in childcare (not with parents): ________________

Do any household members smoke? □ Yes □ No ______________________________________________________

How many caffeinated drinks (tea, coffee, cola) does this child consume per day?

How many hours per day does your child spend in front of a screen (TV, computer, iPod, iPad, etc.)?

What grade is this child? __________________________

Are there any concerns about the child’s school performance? __________________________________________

Any concerns about peer or teacher relationships? _________________________________________________

Sports/exercise: Type __________________________ How often? __________________________ How long ________ min ______________

**FAMILY HISTORY**

Do any family members have any of the following conditions:

Condition Mother Father Sibling Grandparent

□ Asthma □ □ □ □ □

□ Anemia □ □ □ □ □

□ Anxiety □ □ □ □ □

□ Bleeding disorder □ □ □ □ □

□ Cancer □ □ □ □ □

□ Depression □ □ □ □ □

□ Diabetes □ □ □ □ □

□ Heart disease □ □ □ □ □

□ High cholesterol □ □ □ □ □

□ Hypertension □ □ □ □ □

□ Kidney disease □ □ □ □ □

□ Migraines □ □ □ □ □

□ Thyroid disease □ □ □ □ □

□ Seizures □ □ □ □ □

□ Alcohol/drug abuse □ □ □ □ □

□ ADHD □ □ □ □ □

Other: _________________________________________________________________

_________________________ ____________________________

A Service of the College of Nursing

Archer Family Health Care

16939 SW 134 Ave

Archer FL 32615

352-495-2550

352-495-3401 Fax
**CHILD’ NAME:** __________________________________________  **DOB:** ______  **AGE:** ______

**REVIEW OF SYSTEMS** (check all that apply)

**Constitutional**
- Fever, chills
- Fatigue
- Unexplained weight change

**Cardiovascular**
- Chest pain
- Palpitations
- Fainting
- Tires easily with exertion

**Skin and Blood**
- Rash
- Abnormal moles
- Easy bruising
- Easy bleeding

**Eyes**
- Blurry vision
- Squinting
- “Crossed” eyes
- Redness

**Gastrointestinal**
- Diarrhea
- Constipation
- Blood in stool
- Nausea

**Neurologic**
- Headaches
- Seizure
- Milestone delay

**Ears, Nose, Throat**
- Loss or change in hearing
- Snoring
- Nosebleeds
- Earache
- Frequent runny nose
- Sore throat or hoarseness

**Psychiatric/emotional**
- Anxiety
- Depression
- Sleeping problem
- Anger problems
- Attention or impulse problems

**Respiratory**
- Shortness of breath
- Cough
- Wheeze
- Chest tightness

**Genitourinary**
- Frequent or painful urination
- Bedwetting, frequent accidents
- Blood in urine

**Endocrine**
- Excessive thirst
- Excessive urination
- Night sweats

**Musculoskeletal**
- Muscle pain
- Weakness
- Joint pain
- Swelling
- Back pain

**Breast/Chest**
- Breast pain
- Nipple discharge
- Breast lump

Are you sexually active?  □ No  □ Yes

Have you now or ever felt physically, verbally, or emotionally abused, or been punched, kicked, or slapped?  □ No  □ Yes, explain

___________________________________________________________________________________________________________

Boys only:  □ Penile sores  □ Testicular swelling  □ Penile discharge

Girls only:  □ Vaginal discharge □ Irregular periods □ Unexplained vaginal bleeding

Age of first menstruation: __________
Periods occur every ________ weeks
Periods last ________ days
Last menstrual period ________
Number of pregnancies: ________
Number of living children: ________
Number of abortions: ________
Number of miscarriages: ________

Anything else you would like to discuss with the healthcare provider:
___________________________________________________________________________________________________________

___________________________________________________________________________________________________________

___________________________________________________________________________________________________________

___________________________________________________________________________________________________________

Your name: __________________________________________  Relationship to Child: __________________________________________

Patient/Responsible party signature: ___________________________  Date: __________________________

Revised 11/2013: aak
Pediatric Health History Form- Initial Visit

Child’s Name __________________________________________ Date of Birth__________ Age______

CHILD’S PAST MEDICAL HISTORY

Pregnancy/Neonatal Period
Did the mother use any drugs or alcohol during the pregnancy?
□ No   □ Yes If Yes, explain________________________

Where was your child born? ____________________________________________________________
Is the child yours by □ birth □ adoption □ step □ other
Pregnancy complications __________________________________________________________
Was your child premature? □ No □ Yes born at _____ wks.
Delivery □ vaginal □ C-section
Reason for C-section ______________________________________________________________
Delivery complications ____________________________________________________________
Birth weight_______ Birth length________
Any problems in newborn period ___________________________________________________

Infancy/Childhood/Adolescence
Has your child ever been treated or diagnosed with:
□ Allergies □ Asthma or reactive airway disease □ Anemia □ Anxiety
□ Bleeding disorders □ Cancer □ Depression □ Diabetes
□ Fractures or breaks □ Genetic syndrome □ GERD □ Heart disease or heart murmur
□ Kidney disease □ Migraines or headaches □ Vision or hearing problems
□ Sexually transmitted disease □ Seizures □ Sports Injuries (concussions, etc.) □ Other

Has your child ever been hospitalized □ No □ Yes, Explain:______________________________

Previous surgeries and dates _________________________________________________________

Please list any specialists your child is currently seeing and reason:_______________________

Medications
ALLERGIES to medicine or vaccine (list and describe reaction)
_________________________________________________________________________________
_________________________________________________________________________________

CURRENT medications and dose: _______________________________________________________

Vitamins/supplements/over the counter medications: __________________________________

Development/Nutrition
At what age did your child do the following:___________________________________________
walk alone ___________ sit alone ___________ speak ___________ toilet train ___________
Was your child breastfed? □ No □ Yes, for _____ months
Has your child had any dietary problems? ____________________________________________

Current milk intake: Type_________________________ Amount per day_____________________

SOCIAL HISTORY
Who lives at home with the child? □ Mom □ Dad □ Stepparent □ Siblings (# ____ ) □ Grandparents □ Other
Child’s parents are: □ Married □ Unmarried □ Divorced □ Other; ________________________
Childcare: ____________________________
Days per week in childcare (not with parents): ____________
Do any household members smoke? □ Yes □ No
How many caffeinated drinks (tea, coffee, cola) does this child consume per day? _______
How many hours per day does your child spend in front of a screen (TV, computer, IPod, IPad, etc.)? _______
What grade is this child in? __________________
Are there any concerns about the child’s school performance? ____________________________

Any concerns about peer or teacher relationships? ______________________________________

Sports/exercise: Type ___________ How often?_________ How long__________ min

FAMILY HISTORY
Do any family members have any of the following conditions:
Condition □ Mother □ Father □ Sibling □ Grandparent
Asthma □ □ □ □
Anemia □ □ □ □
Anxiety □ □ □ □
Bleeding disorder □ □ □ □
Cancer □ □ □ □
Depression □ □ □ □
Diabetes □ □ □ □
Heart disease □ □ □ □
High cholesterol □ □ □ □
Hypertension □ □ □ □
Kidney disease □ □ □ □
Migraines □ □ □ □
Thyroid disease □ □ □ □
Seizures □ □ □ □
Alcohol/drug abuse □ □ □ □
ADHD □ □ □ □

Other: ____________________________
Child’s Name ____________________________________  Date of Birth____________________  Age_______

REVIEW OF SYSTEMS (check all that apply)

Constitutional
☐ Fever, chills
☐ Fatigue
☐ Unexplained weight change

Cardiovascular
☐ Chest pain
☐ Palpitations
☐ Fainting
☐ Tires easily with exertion

Skin and Blood
☐ Rash
☐ Abnormal moles
☐ Easy bruising
☐ Easy bleeding

Eyes
☐ Blurry vision
☐ Squinting
☐ “Crossed” eyes
☐ Redness

Gastrointestinal
☐ Diarrhea
☐ Constipation
☐ Blood in stool
☐ Nausea
☐ Vomiting
☐ Abdominal pain

Ears, Nose, Throat
☐ Loss or change in hearing
☐ Snoring
☐ Nosebleeds
☐ Earache
☐ Frequent runny nose
☐ Sore throat or hoarseness

Respiratory
☐ Shortness of breath
☐ Cough
☐ Wheeze
☐ Chest tightness

Genitourinary
☐ Frequent or painful urination
☐ Bedwetting, frequent accidents
☐ Blood in urine

Musculoskeletal
☐ Muscle pain
☐ Weakness
☐ Joint pain
☐ Swelling
☐ Back pain

Skin and Blood
☐ Rash
☐ Abnormal moles
☐ Easy bruising
☐ Easy bleeding

Neurologic
☐ Headaches
☐ Seizure
☐ Milestone delay

Psychiatric/emotional
☐ Anxiety
☐ Depression
☐ Sleeping problem
☐ Attention or impulse problems

Endocrine
☐ Excessive thirst
☐ Excessive urination
☐ Night sweats

Boys only:  ☐ Penile sores  ☐ Testicular swelling  ☐ Penile discharge

Girls only:  ☐ Vaginal discharge  ☐ Irregular periods  ☐ Unexplained vaginal bleeding

Are you sexually active?  ☐ No  ☐ Yes

Have you now or ever felt physically, verbally, or emotionally abused, or been punched, kicked, or slapped?  ☐ No  ☐ Yes, explain

________________________________________________________________________________________________________________

________________________________________________________________________________________________________________

Boys only:  ☐ Penile sores  ☐ Testicular swelling  ☐ Penile discharge

Age of first menstruation:__________
Periods occur every _________ weeks
Periods last ___________ days
Last menstrual period ____________
Number of pregnancies:___________
Number of living children:__________
Number of abortions:______________
Number of miscarriages:____________

Anything else you would like to discuss with the healthcare provider:
________________________________________________________________________________________________________________
________________________________________________________________________________________________________________
________________________________________________________________________________________________________________

Your name: ____________________________ Relationship to Child: ____________________________

Patient/Responsible party signature: ____________________________ Date: __________________________

Revised 11/2013: aak
JOINT NOTICE OF PRIVACY PRACTICES
AND NOTICE OF ORGANIZED HEALTH CARE ARRANGEMENT

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact either the Privacy Office for UF Health Shands or the Privacy Office for the University of Florida at the contact information listed below:

UF Health Shands Privacy Office 1-866-682-2372
University of Florida Privacy Office 1-866-876-4472

OUR LEGAL DUTY TO PROTECT HEALTH INFORMATION ABOUT YOU
We understand your health information is personal and we are committed to protecting it. We create a record of the care and services you receive at UF Health Shands or the University of Florida Health Science Center (UFHSC) to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by UF Health Shands and/or the UFHSC, whether made by hospital personnel, University of Florida faculty, staff, students, or your personal doctor. This Notice describes how we may use and disclose your health information, and provides examples where necessary. This Notice also describes your rights regarding your health information.

We are required by law to maintain the privacy of health information, to provide individuals with notice of our legal duties and privacy practices with respect to health information, and to abide by the terms of the notice currently in effect.

CHANGES TO THIS NOTICE
We reserve the right to change our privacy practices and this notice at any time. We reserve the right to make the revised notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at all our facilities.

NOTICE OF ORGANIZED HEALTH CARE ARRANGEMENT
UF Health Shands, which for the purposes of this notice includes Shands Teaching Hospital and Clinics, Inc. and Shands Jacksonville Medical Center, Inc., and the UFHSC, together with the UFHSC clinics* and other affiliated health care providers have agreed as permitted by law, to share your health information among themselves for purposes of treatment, payment or health care operations. This arrangement enables us to better address your health care needs in the integrated setting found within UF Health Shands and the University of Florida health care providers.

The organizations participating in the Joint Notice are participating only for the purposes of providing this Joint Notice and sharing medical information as permitted by applicable law. These organizations are not in any way providing health care services mutually or on each other’s behalf. UF Health Shands and the University of Florida are separate health care providers and each is individually responsible for its own activities, including compliance with privacy laws, and all health care services it provides.

CONSISTENT WITH STATE AND FEDERAL LAW, WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN PERMISSION IN THE FOLLOWING CIRCUMSTANCES:

We may use and disclose your health information to provide medical treatment to you and to coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. For example: we may use and disclose your health information when you need lab work or an x-ray. Also, we may use and disclose your health information when referring you to another health care provider or to recommend treatment alternatives to you.

We may use and disclose your health information to bill and receive payment for services rendered. For example: A bill may be sent to you or your insurance company. The items on, or accompanying, the
bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used so that your health plan will pay the medical bill. We may also tell your health plan about a treatment you are expected to receive in order to obtain prior approval or to determine if your health plan will pay for that treatment.

We may use and disclose your health information for health care operations. We will use your health information for regular operations of the hospital and clinics to provide patients with quality care. For example: Members of the medical staff, the risk management team or the quality improvement team, including Patient Safety Organizations (PSOs), may use information in your health record to assess the care you receive and the outcomes of your treatment. We may also disclose information to doctors, nurses, technicians, medical students and other UFHSC personnel for review and teaching purposes.

We may also use and disclose your health information:

- When necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- To organizations that facilitate donation and transplantation of tissues and/or organs.
- To authorized officials when required by federal, state, or local law.
- In response to a subpoena, court, or other administrative order.
- As required by law, for public health activities. For example: preventing or controlling disease, reporting births and deaths, and reporting abuse and neglect.
- For authorized Worker’s Compensation activities.
- To health oversight agencies. For example: agencies that enforce compliance with licensure or accreditation requirements.
- To coroners, medical examiners, or funeral directors to carry out their duties.
- As required by military command authorities, if you are a member of the armed forces.
- To our business associates to carry out treatment, payment, or health care operations on our behalf. For example: we may disclose health information about you to a company who bills insurance companies for our services.
- For research or to collect information in databases to be used later for research. All research projects are reviewed and approved by an independent review board to protect the privacy of your health information.
- To a correctional institution having lawful custody of you as necessary for your health and the safety of others.

We may also use and disclose your information for fundraising activities to raise money for UF Health Shands or UFHSC and their operations. If you do not want to be contacted for fundraising efforts, you must notify either the UF Health Shands Privacy Office or the University of Florida Privacy Office.

**SPECIAL CIRCUMSTANCES**

Alcohol, Drug Abuse, Psychotherapy Notes, and Psychiatric Treatment Information may have special privacy protections. We will not disclose any health information identifying an individual as a patient or provide information relating to the patient’s substance abuse or psychiatric treatment unless:

1. You or your personal representative consents in writing;
2. A court order requires disclosure;
3. Medical personnel need information to treat you in a medical emergency;
4. Qualified personnel use the information for research or operations activities;
5. It is necessary to report a crime or a threat to commit a crime; or
6. To report abuse or neglect as required by law.
JOINT NOTICE OF PRIVACY PRACTICES
AND NOTICE OF ORGANIZED HEALTH CARE ARRANGEMENT

YOU MAY REFUSE TO PERMIT CERTAIN USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Unless you object, we may use or disclose your health information in the following circumstances:

- **Hospital Directories.** We may share your name, room number, and condition in our patient listing with clergy and with people who ask for you by name. We also may share your religious affiliation with clergy.

- **Individuals Involved in Your Care or Payment for Your Care.** We may use or disclose information to a family member, legal representative, or other persons involved with or responsible for your care or the payment of your care.

- **Emergency Circumstances and Disaster Relief.** We may disclose information about you to an agency assisting in a disaster relief effort so that your family can be notified of your location and general condition. Even if you object, we may still share the health information about you, if necessary for emergency circumstances.

**USES AND DISCLOSURES OF HEALTH INFORMATION THAT REQUIRE YOUR WRITTEN PERMISSION**

Other uses and disclosures of health information not covered by this notice or applicable law will be made only with your written permission. If you provide permission to use or disclose health information, you may revoke that permission at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your revocation. We are unable to take back any disclosures already made with your permission.

We will not use or disclose your protected health information for marketing purposes, nor will we sell your protected health information without your written permission.

**YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

You have the following rights regarding health information we maintain about you:

- **Right to See and Obtain Copies of your Health Information**
  
  You have the right to see and obtain copies of health information used to make decisions about your care. Usually, this includes medical and billing records, and excludes psychotherapy notes.
  
  To view and copy your health information, you must submit your written request on the appropriate form to Health Information Management or the Clinic Manager. We may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to see and obtain copies of your health information in certain very limited circumstances. You have the right to appeal the denial.

- **Right to Amend**
  
  If you think that your health and billing information is incorrect or incomplete, you may ask us to correct it. We may deny your request if:
  
  1) The information was not created by us;
  2) The information is not part of the records used to make decisions about your care;
  3) We believe the information is correct and complete; or
  4) You do not have the right to review parts of the medical record under certain circumstances.

  We will tell you in writing the reasons for the denial and describe your rights to give us a written statement disagreeing with the denial.

  If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, as needed, including persons you name who have received information about you and who need the amendment. Your request must be in writing and include an explanation of your reason(s) for the amendment. The request must be submitted on the proper
form to the Health Information Management or Clinic Manager where you received treatment.

- **Right to an Accounting of Disclosures**
  You have the right to request an Accounting of Disclosures. This Accounting of Disclosures report does not include disclosures made for your treatment, payment, or health care operations. It also does not include disclosures made to or requested by you, or that you authorized.
  You must submit your request for a report in writing to the Health Information Management or the Clinic Manager where you received care. Your request must state a time period, which is limited to the previous six years from the date of the request. The first request for an accounting of disclosures will be provided free of charge. We may charge you for additional report requests made within a 12 month period.

- **Right to Request Restrictions**
  You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. If we agree with your request, we will comply unless the information is needed to provide emergency treatment, is required by law, or otherwise required to be disclosed as listed in this notice.
  You must make your request for restrictions in writing to either the UF Health Shands Privacy Office or the UF Privacy Office. Your request must include what information you want to limit and how you want the limits to apply.
  You have the right to restrict disclosures of health information made to a health plan when the items or services were paid in full prior to being rendered. Certain limitations apply.

- **Right to Choose How We Communicate With You**
  You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example: you can ask that we only contact you at work or by mail. You must make your request for alternate communications in writing to the Admissions supervisor at UF Health Shands, or to the UF Clinic Managers or supervisors. We will not ask you the reason for your request and will accommodate reasonable requests.

- **Right to a Paper Copy of This Notice**
  You have the right to receive a copy of this notice from UF Health Shands or any UF clinic. You may obtain an electronic copy of this notice from our websites at: https://ufhealth.org/patient-care or www.privacy.health.ufl.edu.

- **Right to Breach Notification**
  You have the right to and will receive notification in the event of a breach of your unsecured protected health information, unless such notification is exempted by law.

**COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with us. You will not be penalized or denied services for filing a complaint. To file a privacy complaint with UF Health Shands, please contact the Privacy Office, at, P.O. Box 103175, Gainesville, FL 32610-3175, or call 1-866- 682-2372. To file a privacy complaint with the UFHSC or UF Clinics, please contact the UF Privacy Office at P.O. Box 113210, Gainesville, FL 32611 or call 1-866-876-4472. All complaints must be submitted in writing on the appropriate form that is available on our website: www.privacy.health.ufl.edu. To file a complaint with the Secretary of the Department of Health and Human Services, visit the Office for Civil Rights website at www.hhs.gov/ocr.

*The University of Florida clinics and physicians’ offices; the Florida Clinical Practice Association; the University of Florida Jacksonville Physicians, Inc., the University of Florida Jacksonville Healthcare, Inc.; the University of Florida Colleges of Medicine, Nursing, Health Professions, Dentistry and Pharmacy; the University Proton Therapy Institute; and other affiliated health care providers, including all employees, volunteers, staff and other University of Florida health services staff.*
ACKNOWLEDGEMENT of Receipt

MRN: ___________ PATIENT NAME: ______________________________ VISIT DATE: ___________

I have been provided a copy of the Joint Notice of Privacy Practices for the University of Florida and UF Health Shands. I understand that I may ask questions about this Notice at any time.

Patient Signature: ___________________________________________ Date: ______________________

If not signed by the patient, please indicate relationship:

Legal Representative Signature: _________________________________ Date: ________________

Relationship to Patient: ______________________________________

For Office Use Only:

Signed form received by: _____________________________________

Print Name

____________________________________________

Print Facility Name

☐ Declined to Sign Acknowledgment

Efforts to obtain signature: _____________________________________________

________________________________________

Reasons for refusal:
**AUTHORIZATION to Use or Disclose Protected Health Information (PHI)**

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>Date of Birth</th>
<th>Verification of Identity (Driver's License, ID Card, Passport, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient's Address</td>
<td>Medical Record Number</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Complete the following only if the person authorizing the use or disclosure is not the patient:**

<table>
<thead>
<tr>
<th>Representative’s Name</th>
<th>Relationship to Patient</th>
<th>Legal Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Representative’s Address</td>
<td>Verification of Identity</td>
<td>Verification of Authority</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**By signing this form, I authorize the following:**

<table>
<thead>
<tr>
<th>Disclosure of the patient’s PHI from:</th>
<th>Disclosure of the patient’s PHI to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person, class of persons, or organization</td>
<td>Person, class of persons, or organization</td>
</tr>
<tr>
<td>Address</td>
<td>Address</td>
</tr>
<tr>
<td>16939 SW 134th Ave</td>
<td>Archer FL 32618-5413</td>
</tr>
</tbody>
</table>

Attn: Medical Records

Phone 352-495-2550

Fax 352-495-3401

The following protected health information may be disclosed:

I further authorize the disclosure of the following information which may be included in the protected health information listed above. (Check all that are approved.)

- [ ] Mental Health
- [ ] Substance Abuse
- [ ] HIV/AIDS
- [ ] Records created by non-UF/Shands providers

The purpose of the disclosure is:

I understand that, by federal law, the University of Florida may not use or disclose protected health information without authorization except as provided in the University’s Notice of Privacy Practices. By signing this Authorization, I am giving permission for the uses and disclosures of the described protected health information. I hereby release the University of Florida and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that I have the right to revoke this Authorization at any time, if I do so in writing, and address it to the person or institution named above. I understand that the revocation will not apply to any actions already taken as a result of this authorization.

I understand that I may refuse to sign this Authorization, and that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

I understand that information disclosed pursuant to this Authorization may no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

I understand that I may be charged a fee of up to $1.00 per page (plus applicable tax and handling) for every page copied and that this fee is within the limits allowed by Florida law.

This authorization expires automatically one (1) year from the date signed, if no other date or event is specified.

Expiration Date or Event

This authorization may be used to disclose protected health information of the same type described above, which may be created in the future, until the expiration date.

- [ ] YES
- [ ] NO

I have read and understand the information in this authorization form.

Signature of Patient or Legal Representative: Date
2016-17 APPLICATION FOR REDUCED COPAYMENT HEALTH CARE

Based on the information you provided, it appears that you may qualify for reduced co-payment. Please fill out the following form completely and honestly. List all income from all sources including Self-employment, Contributions from friends/relatives, Social Security Benefits, Pensions, Interest, Dividends, Child Support, Veterans Benefits, Unemployment/Workers’ Compensation, Railroad Retirement, Annuities/Rent, Food Stamps and any other government assistance. List all types of assets including Cash, Checking Account, Savings Account, Property/Land, Cars, Trucks, Motorcycles, Boats, Life Insurance, Trust Funds, Stocks, Bonds, CD’s.

NAME: ____________________________ SOCIAL SECURITY # _____ - ____ - ______ DATE OF BIRTH __________

**************************HOUSEHOLD MEMBERS**************************

List yourself and all other household members and your relation to them. List the total monthly income for each family member. If a member has no incomes list the reason. Indicate if a member has Medicaid or Food Stamps. All patients applying for free or reduced services should apply for Medicaid and Food Stamps. If a member does not have Medicaid or Food Stamps state the reason for denial.

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Relation to You</th>
<th>Date of Birth</th>
<th>Monthly Income and Source</th>
<th>Medicaid or Food Stamps</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Rights and Responsibilities for Financially Assisted Health Care

Archer Family Health Care provides medical care at reduced charges. The charges are based on income and asset information. Services will be provided at a $10.00 charge to individuals at or below the Federal Poverty guidelines and reduced fees will apply up to 200% of the Poverty guideline.

I am applying for reduced co-payment for my medical care to be received at Archer Family Health Care. I understand that Reduced co-payment services do not apply to outside laboratories or referrals for services performed outside of Archer Family Health Care. I understand that I have to give true and complete information on this form under penalty of perjury and can be prosecuted if I lie or hide information.

I agree that Archer Family Health Care and University of Florida, College of Nursing may verify the information I give on this form. I agree that they may contact my present or past employers if it relates to my eligibility. I agree that they may get information that affects my eligibility from any records or sources including information exchanges with other agencies.

I agree to notify Archer Family Health Care of any change in my situation immediately.

I have read and kept a copy of my Rights and Responsibilities. I declare the information provided on the other side of this form is true to the best of my knowledge. If false information is reported on this application you will be discharged from Archer Family Health Care.

Signature of Applicant/Guardian _______________________________ Date _______________________________

Witness _______________________________ Date _______________________________

Revised 6/2/16 dba