Premier Community HealthCare Group, Inc.
Patient Information Form

Patient Information

1. Name _____Date of Birth: _____
1. Mailing Address: _____ Physical Address: _____
2. City: _____ State: _____ Zip Code: _____
3. Home Phone: _____ Cell Phone: _____ Work Phone: _____

   Preferred Phone: □ Home □ Mobile □ Work

   Preferred Method of Appointment Reminders: □ Voice □ Text □ Email □ Do Not Contact
4. E-mail Address: _____
5. Marital Status: □ Single □ Married □ Divorced □ Widowed
6. Gender: □ Female □ Male

Questions 8 & 9 are not required for patients less than 18 years of age.

Collecting gender identity and sexual orientation data is important to help reduce health disparities and promoting culturally competent care in health centers.

7. Sexual Orientation (a person's sexual identity in relation to the gender to which they are attracted)

   □Lesbian/Gay □Straight (not lesbian/gay) □Bisexual

   □Other_____ □Don't Know □Choose not to disclose
8. Gender Identity (a person's perception of having a particular gender, which may or may not correspond to the gender they were at birth.)

   □Male □Female □Transgender Male(Female-to-Male) □Transgender Female(Male-to-Female)

   □Other _____ □Choose not to disclose
9. Race: □ White □ Black □ Am. Indian/Alaskan Native □Native Hawaiian □ Other Pacific Islander

   □ Asian □More than one race □Decline
10. Ethnicity: □ Hispanic/Latino □Not Hispanic/Latino Preferred Language: _____
11. Employment Status: □Employed □Self Employed □Unemployed □Disabled

    □Retired □Full Time Student □Part Time Student Employer/School Name: _____
12. Do you have medical insurance? □Yes □No If yes, name of insurance? _____

    Do you have dental insurance? □Yes □No If yes, name of insurance? _____
13. Emergency Contact: _____ Relationship: _____

    Phone number: _____ Preferred Language: _____

14. Parent/Legal Guardian Information: (complete only if patient is a minor)

    Mother's Name: _____ Date of Birth: _____ Gender: □Male □Female

    Father's Name: _____ Date of Birth: _____ Gender: □Male □Female

    Guardian's Name: _____ Date of Birth: _____ Gender: □Male □Female
15. Phone Number: _____ E-mail Address: _____
16. Marital Status: □ Single □ Married □ Divorced □ Widowed
17. Race: □White □ Black □Am. Indian/Alaskan Native □Native Hawaiian □Other Pacific Islander □Asian □More than one race □Decline
18. Employment Status: □Employed □Self Employed □Unemployed □Disabled □Retired

    □Full Time Student □Part Time Student Employer/School Name:_____

19. Do you have internet access? □ Yes □ No

20. Premier participates in the 340B Drug Pricing Program. This program is a U.S. federal government program that requires drug manufacturers to provide outpatient drugs to eligible health care organizations/covered entities at significantly reduced prices.

    Premier patients can opt to have prescriptions prescribed by Premier providers filled under this program by using one of the following pharmacies. By doing so this will allow eligible patients to receive a reduced price for qualified prescriptions.

	Pharmacy #	Pharmacy Address	City
	Walgreens #6540	13053 Cortez Blvd	Brooksville
	Walgreens #7916	20020 Cortez Blvd	Brooksville
	Walgreens #4811	12807 Us Highway 301	Dade City
	Walgreens #12318	2480 Us Highway 19	Holiday
	Walgreens #3629	12028 Majestic Blvd	Hudson
	Walgreens #4400	8951 Hudson Ave	Hudson
	Walgreens #7466	14217 Us Highway 19	Hudson
	Walgreens #3793	4510 Us Highway 19	New Port Richey
	Walgreens #5131	10401 Little Rd	New Port Richey
	Walgreens #5414	9220 Little Rd	New Port Richey
	Walgreens #5857	7420 State Road 54	New Port Richey
	Walgreens #6886	7020 Massachusetts Ave	New Port Richey
	Walgreens #16526	8400 Us Hwy19 N	Port Richey
	Walgreens #2192	11180 Spring Hill Dr	Spring Hill
	Walgreens #4289	4255 Commercial Way	Spring Hill
	Walgreens #5858	14320 Spring Hill Dr	Spring Hill
	Walgreens #7733	7305 Spring Hill Dr	Spring Hill
	Walgreens #12391	4096 Mariner Blvd	Spring Hill
	Walgreens #16262	105 Mariner Blvd	Spring Hill
	Walgreens #6412	28115 Wesley Chapel Blvd	Wesley Chapel
	Walgreens #5604	6429 Gall Blvd	Zephyrhills
	Walgreens #11790	36515 State Road 54	Zephyrhills
	Walgreens #12103	9819 Commercial Way	Weeki Wachee

	Pharmacy #	Pharmacy Address	City
	CVS #03528	12990 CORTEZ BLVD	BROOKSVILLE
	CVS #01293	12804 US HWY 301	DADE CITY
	CVS #01328	2513 US HWY 19	HOLIDAY
	CVS #01316	13839 LITTLE RD	HUDSON
	CVS #03583	12015 LITTLE RD	HUDSON
	CVS #00306	5432 US HWY 19 N	NEW PORT RICHEY
	CVS #03260	7325 STATE RD 54	NEW PORT RICHEY
	CVS #05146	3511 US HWY 19	NEW PORT RICHEY
	CVS #03217	11938 US HWY 19 N	PORT RICHEY
	CVS #05660	7120 RIDGE RD	PORT RICHEY
	CVS #03746	11115 SPRING HILL DR	SPRING HILL
	CVS #08380	2077 COMMERCIAL WAY	SPRING HILL
	CVS #00709	1000 E TARPON AVE	TARPON SPRINGS
	CVS #03758	9204 CORTEZ BLVD	WEEKI WACHEE
	CVS #01527	5606 POST OAK BLVD	WESLEY CHAPEL
	CVS #00651	37943 EILAND BLVD	ZEPHYRHILLS
	CVS #03619	36440 STATE RD 54	ZEPHYRHILLS
	CVS #07176	34502 SR 54	ZEPHYRHILLS
	PINE BROOK PHARMACY LLC	11373 CORTEZ BLVD, Suite 101	BROOKSVILLE
	PINE BROOK PHARMACY LLC.	14111 CORTEZ BLVD	BROOKSVILLE
	RPH SOLUTION INC	14306 7TH ST	DADE CITY
	RELIANT PHARMACY LLC	10507 SPRING HILL DR	SPRING HILL
	SHREY PHARMACY LLC	5340 SPRING HILL DR	SPRING HILL
	ZEPHYRHILLS COMMUNITY PHARMACY, LLC	6242 GALL BLVD	ZEPHYRHILLS
	VASO RPH SOLUTION INC	38008 NORTH AVE	ZEPHYRHILLS
	Walmart #10-0713	12650 Hwy 301 South	Dade City
	Walmart #10-1085	8701 US HWY 19	Port Richey

Please check pharmacy above or list the pharmacy preferred: _____

Address: _____ Phone: _____

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21. Check your living arrangements: □ Own/Rent □ Shelter □ Homeless □ Public Shelter
□Living with friend/doubling up □Street/Car □Transitional □Other _____
22. In the past two years, or prior to retirement or disability:
    - Have you or the head of your household worked in agriculture? □Yes □No
    - Did you or the head of your household move from this area to another County or State in search of agricultural work? □Yes □No
    - Has your family lived in this area and earned more than half their income from seasonal agriculture? □Yes □No
23. Are you a Military Veteran? □Yes □No Military Discharge? □Yes □No Discharge Date: _____
24. Are you a refugee? □Yes □No Country of Origin: _____
25. Circle your household size and annual household income range. *Information for reporting purposes only.*

Household Size	*From*	*To*	*From*	*To*	*From*	*To*	*From*	*To*	*From*	*To*
1	$ -	$14,580	$ 14,581	$ 19,391	$ 19,392	$ 24,203	$ 24,204	$ 29,160	$ 29,161	and up
2	$ -	$19,720	$ 19,721	$ 26,228	$ 26,229	$ 32,735	$ 32,736	$ 39,440	$ 39,441	and up
3	$ -	$24,860	$ 24,861	$ 33,064	$ 33,065	$ 41,268	$ 41,269	$ 49,720	$ 49,721	and up
4	$ -	$30,000	$ 30,001	$ 39,900	$ 39,901	$ 49,800	$ 49,801	$ 60,000	$ 60,001	and up
5	$ -	$35,140	$ 35,141	$ 46,736	$ 46,737	$ 58,332	$ 58,333	$ 70,280	$ 70,281	and up
6	$ -	$40,280	$ 40,281	$ 53,572	$ 53,573	$ 66,865	$ 66,866	$ 80,560	$ 80,561	and up
7	$ -	$45,420	$ 45,421	$ 60,409	$ 60,410	$ 75,397	$ 75,398	$ 90,840	$ 90,841	and up
8	$ -	$50,560	$ 50,561	$ 67,245	$ 67,246	$ 83,930	$ 83,931	$101,120	$ 101,121	and up

_____ _____
Patient's Signature **Date**

_____ _____ _____
Signature of Parent or Patient's Representative (if applicable) **Date** **Relationship to Patient**

Office Use Only

Care Team Member Signature: _____ **Date:** _____

PREMIER
Community HealthCare

Patient Name: _____
Date of Birth: _____
Account Number: _____

Medical Home

A Patient Centered Medical Home is not a building, house or hospital, but rather an approach to providing total health care. A Medical Home is called a "Home" because we'd like this office to be the first place you think of for all your health care needs.
I choose to participate in the Patient Centered Medical Home program.

Release of Information

Protected health care information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or any other purpose related to benefit payment.

If I am covered by Medicaid, Medicare or other Health Plan, I authorize the release of protected health care information to the appropriate agency for payment of the claim. The information may include, without limitation, history and physical, emergency records, laboratory reports, drug and alcohol treatment and discharge summary.

Federal and state laws may permit this facility to participate in organizations with other health care providers, insurers, and/or health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not limited to: improving the accuracy and increasing the availability of my health records, decreasing the time needed to access my information, continuity of care; and such other purposes as may be permitted by law. I understand this facility may be a member of such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases such as HIV and AIDS.

I hereby authorize the practice and the physicians or other health professionals involved in my care to release health care information for purposes of treatment, payment and/or health care operations.

Patient Rights & Responsibilities, HIPAA and Financial Policy

These documents are posted in the lobby and on our website: www.premierhc.org. I acknowledge that I have received or have been allowed to view a copy of each and understand and agree to the terms set forth in the policies.

Disclosures to Family Members and or Friends

I give permission for my protected health information to be disclosed for purposes of coordination, healthcare needs, communicating results, findings and care decisions to the family members and or friends listed below.

** You have the right to revoke whom we talk with about your health care at any time. You must sign a new consent.

Name	Relationship	Contact Number

Consent for treatment

I hereby consent and authorize treatment at Premier Community Healthcare Group Inc, (PCHG), for myself.

Consent for treatment of a Minor

I, as the parent or legal guardian, do hereby give my consent and authorization for treatment of my child _____. Furthermore, I grant permission for the following individuals to authorize Medical/Dental treatment in my absence.

Name	Relationship	Contact Number

If you wish to grant permission to another individual for future visits, please complete the Designation of Health Care Surrogate for Minor form.

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Sliding Fee Discount Program

PCHG offers a sliding fee discount program (SFDP) based on a patient's ability to pay for services. The SFDP is established and implemented to ensure that uniform and reasonable fees and discounts are consistently and appropriately applied to all health center patients to address financial barriers to care. Eligibility for the SFDP will be based on income and family/household size.

PCHG does not and cannot require individuals to enroll in public or private insurance and this is not a factor when determining eligibility. However, PCHG educates patients based on their eligibility for public or private insurance for which they might qualify.

Patients that provide documentation and qualify for the sliding fee discount program will remain eligible for the program for 1 year. Those patients that qualify using the Financial Self-Assessment form will be valid for up to 30 days to 1 year depending on eligibility. Patients may reapply, before expiration, for the sliding fee discount program anytime there is a change in income and/or household size. After expiration patients will be reassessed for eligibility for the SFDP.

After Hours Non-Emergency Services

Patients have after-hour access to on-call Premier providers 24 hours a day, seven days a week through an answering service by calling **(352)518-2000**. For medication refills please contact your pharmacy or Premier during normal business hours.

For emergency services call **911** or go to the nearest hospital emergency room.

Notice of Policy Regarding Advanced Directives (for patients over 18 years of age)

Advanced Directives are legal statements that indicate the type of medical treatment desired or not desired in the event an individual is unable to make decisions as well as who is authorized to make them. Advance directives are made and witnessed prior to serious injury or illness. In accordance with federal and state law, this serves as notification that we will set aside your advanced directives in the event you experience a life-threatening event while at one of the PCHG locations and you will be transferred to a higher level of care, i.e. hospital.

Please indicate below whether you have an advanced directive or if you would like to receive information on advanced directives.

- □ I have an advanced directive.
- □ I do not have an advanced directive.
- □ I would like to receive information on advanced directives.

Outreach and Enrollment

The Community Services team provides application assistance with Medicaid, Food Stamps (SNAP), Unemployment, Florida KidCare, and Health Insurance Marketplace. They can also provide community resources for services not offered at Premier. Does the patient require Community Services Assistance?

☐ Yes, I want to receive information on Community Services Assistance.

Residents and Students

I understand that Premier Community HealthCare Group, Inc., supports education of medical/dental professionals and maintains residents and students that may assist in relation to your care.

Missed Appointment Policy

It is our top priority to serve our patients with quality care. When a patient makes an appointment, it creates a commitment between the patient and Premier Community HealthCare. For our providers and care team to best serve all patients, a 24-hour notice to cancel or reschedule and appointment is required. Patients that have a history of 3 or more missed appointments in a calendar year will be limited to making same day appointments or being offered walk-in visits where available.

Premier Community HealthCare Group, Inc. is a Health Center Program grantee under 42 U.S.C. 254b and is deemed a Public Health Service employee under 42 U.S.C. 233(g)-(n) with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals. For more information, you may contact our corporate office at 352-518-2000 or visit http://www.bphc.hrsa.gov/ftca/.

By signing below, I agree, understand and consent to all in this notification.

Patient Signature _____Date_____

Signature of Parent or Patient's Representative _____Date_____

Office Use Only

Care Team Member Signature: _____ **Date:** _____