SAINT JOHN'S COUNTY HEALTH DEPARTMENT

Patient information

Date:_____Time:_____ New Patient ☐ Established Patient ☐

Last Name:_____First:_____Middle:_____

Address:_____

Telephone Number:_____Type: Cell – Home – Work - Other

City:_____State:_____Zip Code:_____

Date of Birth:_____

Race:_____ Primary Language:_____ Gender: ☐Male ☐Female

Ethnicity: ☐ Hispanic/Latino ☐ Unknown/Unreported ☐ Non-Hispanic/Latino

Name of person bringing child:_____ Relationship to child:_____

Florida HEALTH
St. Johns County

Out of State Records Transfer
Completion Sheet

Date Rec'd by Clerk: _____ Time Rec'd by Clerk: _____

Date Completed by Clerk: _____ Time Completed by Clerk: _____

Date Rec'd by Nurse:_____ Time Rec'd by Nurse:_____

Date Completed by Nurse:_____ Time Completed by Nurse:_____

_____ Out of State Records have been transferred to Florida Shots. Your child is up to date on all required immunizations and the 680 form for school is ready to be picked up.

_____ Out of State Records have been transferred to Florida Shots. Your child will need immunizations in order to receive a 680 form for school. Please return with your child during immunization clinic hours.

Florida HEALTH
St. Johns County

INITIATION OF SERVICES

PART I. **CLIENT – PROVIDER RELATIONSHIP CONSENT**

Client Name: _____

Name of Agency: Florida Department of Health in St. Johns County

Agency Address: 200 San Sebastian View, St. Augustine, FL. 32084

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

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

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

PART III. **COMMUNICATIONS**

I understand the Florida Department of Health (DOH) uses a patient portal to communicate with me about my healthcare. In order to receive electronic communications about my health care. I need to provide my email address to the department and then I will be contacted by email to create a portal account.

I understand that I must agree to the terms and conditions of use associated with the portal when I create my account. I understand that the portal is password protected and that I am responsible for maintaining the confidentiality of my user name and password and for all activities that are conducted through my portal account. I understand that I will receive emails letting me know that DOH has sent information to the portal.

____Initial here to authorize and give my express consent to the DOH to make your health care information available to you through the portal.

Email Address: _____.I understand that I have a right to stop participation in the portal at any time by either removing my email address or closing my portal account.

____Initial here to remove your email address from the DOH system and stop receiving information through the portal.

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

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

PART V. **ASSIGNMENT OF BENEFITS** (Only applies to Third Party Payers)

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

PART VI. **COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER** (This notice is provided pursuant to section 119.071(5) (a). Florida Statutes.)

For health care programs the Florida Department of Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071 (5)(a)2.a. and 119.071(5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Florida Department of Health is imperative for the performance of duties and responsibilities as prescribed by law.

PART VII. **MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS**

_____ _____ _____

Client/Representative Signature | Self or Representative's Relationship to Client | Date

_____ _____

Witness (optional) | Date

PART VIII. **WITHDRAWAL OF CONSENT**

1._____ WITHDRAW THIS CONSENT, effective _____

Client/Representative Signature | Date

_____ _____

Witness (optional) | Date

Client Name: _____

ID#:_____

DOB: _____

Original to file; Copy to client

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