3015 Herring Ave • Sebring, Florida 33870
Tel. (863) 471-1870 • Fax. (863) 382-0963
Email. WeCare@samaritanstouch.org
Website. www.SamaritansTouch.org

Eligibility Requirements

Once you have obtained the required documentation, please call to schedule a eligibility appointment

1. **Photo Identification (provide one of the following):**
   - State issued Driver's License
   - State issued ID
   - College ID
   - Visa
   - Passport
   - Work Permit
2. **Proof of Address (provide one the of the following):**
   - Utility Bill (lights, cable, water)
   - Bank Statement
3. **Proof of any/all income for the most current (8) eight week period for all household members:**
   - Paystubs
   - Social Security Benefits
   - Unemployment Benefits
   - Disability Benefits
   - Pensions
   - Food Stamp Benefits
4. **If you are self-employed you must provide:**
   - Bank statements for the previous (3) three months for all household members and/or
   - Payment statements from anyone who has paid you, within the last (3) three months
5. **If anyone is giving you money, providing you room and board or paying any of your bills, that person must complete:**
   - A notarized Statement of Support (included in patient application). STCC does provide a free notary service on-site by appointment for this purpose.
6. **Most recent Tax Return (1040, 1040EZ, 1040A, Schedule C):**
   - ❖ If you do not file taxes or do not have access to your tax return, and you wish to be eligible for the Prescription Assistance Program you will be required to submit an official Tax Return Transcript or Verification of Non-Filing.
   - ❖ An official Tax Return Transcript/Verification of Non-Filing can be easily obtained by logging onto http://www.irs.gov/Individuals/Order-a-Transcript or by submitting Form 4506-T to the IRS. This form can be obtained from the IRS website or STCC. If needed, STCC staff can fax this form to the IRS for you.
7. **Medicaid Determination Letter**
   - ❖ EVERYONE must apply for Medicaid with the Department of Children & Families. Please note that you WILL NOT be eligible for the Prescription Assistance Program until the Medicaid Determination letter is submitted.
   - ❖ STCC is an ACCESS site. You may apply at STCC at your convenience or apply online at http://www.myflorida.com/accessflorida/ or call (800) 762-2237.

Requisitos de Elegibilidad

Una vez que se cuente con la documentación requerida, por favor llame para hacer una cita de elegibilidad.

1. Identificación con foto (proporcionar uno de los siguientes):
- Licencia de conducir del Estado
- Identification del Estado
- Identification del Colegio
- Visa
- Pasaporte
- Permiso de Trabajo

2. Comprobante de domicilio (proporcionar en el de los siguientes):
- Factura de servicios públicos (luz , cable , agua)
- Estado de cuenta bancaria

3. Prueba de / todos los ingresos de un periodo de ocho semanas para todos los miembros del hogar:
- Talones de pago
- Beneficios del Seguro Social
- Beneficios de desempleo
- Beneficios por Incapacidad
- Pensiones
- Beneficios de Cupones para Alimentos

4. Si usted trabaja por cuenta propia debe proporcionar:
- Estados de cuenta bancarios de los últimos tres (3) meses de todos los miembros del hogar y / o
- declaraciones de pago de cualquier persona que usted ha pagado , dentro de los últimos (3) tres meses

5. Si alguien te da dinero , o te proporciona alojamiento y comida o paga algunas de sus cuentas, esa persona debe completar:
- Una declaración notariada de la Ayuda (comprendidos en la demanda del paciente) . STCC proporciona un servicio de notario gratuito para este fin.

6. La mayor declaración de impuestos reciente (1040 , 1040EZ , 1040A, Anexo C):

ϖ Si no declaras impuestos o no tiene acceso a su declaración de impuestos , se le pedirá que presente una Declaración de Impuestos Transcripción oficial. Por favor, tenga en cuenta que los pacientes nuevos no serán elegibles para el Programa de Asistencia hasta que se presente la declaración de impuestos o de Declaración de Transcripción .

ϖ Un funcionario de Declaración de transcripción se puede obtener fácilmente por la dirrecion de computadora http://www.irs.gov/Individuals/Order-a-Transcript o presentando el Formulario 4506 -T del IRS. Este formulario se puede obtener en el sitio web del IRS o STCC . Si es necesario , el personal de STCC puede enviar por fax este formulario al IRS por usted.

7. Medicaid Carta de determinación

ϖ TODOS deben solicitar Medicaid en el Departamento de Niños y Familias . Por favor, tenga en cuenta que los pacientes nuevos no serán elegibles para el Programa de Asistencia hasta que se presente la carta de determinación de Medicaid.

ϖ STCC es un sitio de acceso. Usted puede solicitar en STCC a su conveniencia o en la dirrecion de computadora http://www.myflorida.com/accessflorida/ o llame al (800) 762-2237.

Samaritans Touch Care Center

Intake and Eligibility Questionnaire / Formulario de Admisión y Elegibilidad

Name of the Patient / Nombre del paciente: ______________________________

DOB / Fecha de Nacimiento: ______________________

1. Reason for initial visit / Cual es la razón de su visita inicial:

____

____

2. Please list all medications you have been taking / Anote todos los medicamentos que ha estado tomando:

____

____

3. Is your medical condition the result of an accident? / Es su condición el resultado de un accidente?

□ Yes / Sí □ No If yes, please explain / Por favor explique:

____

4. Is this a work related injury? / ¿Es esta una lesión relacionada con el trabajo?

□ Yes / Sí □ No If yes, please explain / Por favor explique:

____

5. Have you or are you planning on filing for Social Security Disability or Disability Benefits? / ¿Esta usted recibiendo o planeando aplicar para beneficios de Incapacidad del Seguro Social?

□ Yes / Sí □ No If yes, please explain / Por favor explique:

____

6. Have you or are you planning on retaining an attorney (including disability) in relation to any condition/injury? / ¿Tienes o estás pensando en contratar a un abogado (incluida la Incapacidad) en relación con cualquier condición / o lesion?

□ Yes / Sí □ No If yes, please explain / Por favor explique:

____

7. Are you currently under the care/supervision of any other physician for any aspect of your medical care? / ¿Está usted actualmente bajo el cuidado o supervisión de cualquier otro médico para cualquier aspecto de su salud médica?

□ Yes / Sí □ No If yes, what are you being treated for? /¿Qué tratamiento estas recibiendo?

____

8. Have you ever been hospitalized or treated for chronic pain? / ¿Alguna vez ha sido hospitalizado o tratado de dolor crónico?

□ Yes / Sí □ No If yes, what is the condition and where were you treated? / ¿Cuál es el estado y donde lo trataron?

____

9. Is treatment for your chronic pain the reason you are seeking services at Samaritan's Touch Care Center? / ¿El tratamiento para el dolor crónico es la razón que usted está buscando los servicios en el Centro de Atención Samaritans Touch?

□ Yes / Sí □ No

10. Have you ever been hospitalized or treated for psychiatric, mental health or an emotional disorder? / ¿Alguna vez ha sido hospitalizado o tratado, de salud mental psiquiátrica o de un trastorno emocional?

□ Yes / Sí □ No If yes, what is the condition and where were you treated? / ¿Cuál es el estado y donde lo trataron?

____

Samaritans Touch Care Center

11. Is treatment for a psychiatric, mental health or emotional disorder the primary reason for seeing services at Samaritan's Touch Care Center? / ¿Es su salud mental la razon principal que usted esta aplicando en el Centro Samaritans Touch?
□ Yes / Sí □ No

12. Did you report your income last year by filing a federal tax return with the IRS? / ¿Reportó sus ingresos el año pasado con una declaración federal de impuestos con el IRS?
□ Yes / Sí □ No □ Filed Extension / Extensión If no, why not? / Si no, ¿por qué no?

Section 1: Please complete the following information. / Sección 1: Complete la siquiente información.

Full Legal Name / Nombre legal complete:		**Today's Date / Fecha de hoy:**
Date of Birth / Fecha de nacimiento: **Sex / Sexo:** □ Male / Masculino □ Female / Femenino	**Marital Status / Estado civil:** □ Annulled / Anulado □ Divorced / Divorciado □ Legally Seperated / Separado □ Married / Casado □ Never Married / Nunca Casado □ Domestic Partner / Pareja de Hecho □ Widowed / Viudo	**Preferred Language / Idioma preferido:** □ English / Inglés □ Spanish / Español □ Haitian Creole / criollo haitiano □ Other, I speak / Otro, hablo
Maiden Last / Nombre de Soltera	**Social Security Number / Numero de Seguro Social:**	**Driver's License State & Number / Licencia de condcir numero y el estado**
Ethnicity / Etnicidad □ Non-Hispanic / Latino □ Hispanic / Latino	**Race / Grupo étnico:** □ Alaskan Native or Native American / Nativo de Alaska o Nativo Americano □ Asian / Asiático □ Black/African American / Negro/afroamericano □ Decline to specify / No quiero □ Native Hawaiian or other Pacific Islander / Nativo de Hawaii or de las Islas del pacifico □ Other Race / Que otra raza □ Unknown / Desconocido □ White / Blanco	
Home Address / Dirección	**City / Ciudad Estado**	**State & Zip Code / Código y Postal**

Phone Numbers / Números de teléfono:

Check ONE that you want us to call first / Marque UNO que quiere ser contactado primero. Home

Phone / Teléfono de la casa: ______________________ □ Prefer we call first?Dejenos saber a que telefono prefieres que te llamemos?

Cell Phone / Teléfono celular: ______________________ □ Prefer we call first?Dejenos saber a que telefono prefieres que te llamemos?

Work Phone / Teléfono del trabajo: ______________________ □ Prefer we call first?Dejenos saber a que telefono prefieres que te llamemos?

Email address / Correo Electronico

Are you a citizen of the United States? / ¿Es usted ciudadarno de los Estados Unidos?	**Nationality: Birth City, State, Country / Nationalidad: Ciudad Natal, Estado o Condado**

□ Yes / Sí □ No *Su respuesta no afectará su elegibilidad.*	

What is the highest level of education you completed? ¿Cuál es el nivel educativo más alto que ha alcanzado?

- □ Elementary School / Escuela Elamental
- □ Some secondary or high school / Escuela Secondaria
- □ Completed high school or secondary school / Superior
- □ Some college education / Algun Colegio
- □ Associates or technical degree / Escuela Tecnica o Asociados
- □ College or baccalaureate degree / Universidad o bactillerato
- □ Some graduate education / Algun tipo de postgrado
- □ Graduate or professional degree / Titulo profesional
- □ Doctoral or post graduate education / Educacion, Doctorado o de postgrado

What is your Religious Affiliation? / Cual es su afiliacion religiosa?

Which Pharmacy would you like future prescriptions called into? / ¿Qué Farmacia prefieres para que llamemos tus recetas?

How did you hear about Samaritans Touch? / ¿Cómo se enteró acerca de la Clinica Samaritans Touch?

Emergency Contact Name / Contacto de Emergencia:	Relationship / Relación:	Address / Dirección:	Phone / Teléfono:

Are you a veteran? / ¿Es usted un veterano?
- □ No
- □ Yes / Sí

Are you currently working? / ¿Está trabajando actualmente?
- □ Yes, full time / Sí, tiempo completo
- □ Yes, part time / Sí, parcial
- □ Yes, I am self-employed / Sí por cuenta propia
- □ No, last date of work was / No, última fecha de trabajo fue

____

If no, please answer the following. Reason for unemployment? / Si no, por favor conteste lo siguiente? Motivo del desempleo

____

Where do you currently live? / ¿Dónde vives actualmente?
- □ Own/rent apartment or house / Propietario / apartamento de alquier o casa
- □ Staying with friends/relatives / Vivo con amigos / familiares
- □ Shelter / Refugio
- □ Transitional Housing / Vivienda de transición
- □ Homeless (living on the street, in car, in woods, ect) / Sin Hogar (que viven en la calle, o en el coche, ect)

Who is your current employer? If you are not currently working, who was your most recent employer? / ¿Quién es tu patron actual? Si usted no está trabajando actualmente, quien fue su empleador más reciente?

Are you a migrant agricultural worker? / ¿Es usted un trabajador agrícola o un imigrante?
□ Yes / Sí □ No

Are you currently a student? / ¿Está usted actualmente estudiando?
- □ Yes, part-time / Sí, tiempo parcial
- □ Yes, full-time / Sí, tiempo completo
- □ No

If yes, what school do you attend? ¿A qué escuela asiste?

Section 3: Health Care History / Sección 4: Historial de su salud

Is there a particular doctor's office, health center, or other place that you usually go if you are sick or need advice about your health? / ¿Hay un consultorio medico, centro de salud, o cualquier otro lugar que sueles ir si usted está enfermo o necista consejo sobre su salud? □ Yes / Sí □ No

If no, have you ever been a regular patient at a health center or doctor's office? / Si no, ¿alguna vez has sido paciente regular en un centro de salud o consultorio medico? □ Yes / Sí □ No

When (what year) were you last seen as a patient there? / ¿Cuándo fue el año que fue paciente del censultorio? ___________

Where would you go to get care for a sudden medical problem such as a sinus infection or an abscessed tooth? Check ONLY ONE. / ¿Dónde suele ir a recibir atención por un medico, como una infección o un absceso dental? Marque SOLO UNA.

□ Health Department / Departamento de Salud □ Central Florida Health Care / de la Florida Central de Atención de Salud
□ Emergency Room / Sala de Emergencia □ Personal Doctor / Médico Personal
□Other (please describe) / Otro (describa) _______________

Where would you typically go to get checked for chronic issues such as diabetes, high blood pressure, heart disease, asthma or other chronic illness? Check ONLY ONE. /¿Dónde suele ir para problemas crónicos como la diabetes, presión arterial alta, enfermedades del corazón, asma u otra enfermedad crónica? Marque SOLO UNA.

□ Health Department / Departamento de Salud □ Central Florida Health Care / de la Florida Central de Atención de Salud
□ Emergency Room / Sala de Emergencia □ Personal Doctor / Médico Personal
□ Other (please describe) / Otro (describa) _______________

Where would you go to get checkups, physicals, shots/immunizations, or other preventative care? Check ONLY ONE. / ¿A dónde iría a hacerse, examines físicos, vacunas / inmunizaciones, u otro cuidado preventivo? Marque SOLO UNA .

□ Health Department / Departamento de Salud □ Central Florida Health Care / de la Florida Central de Atención de Salud
□ Emergency Room / Sala de Emergencia □ Personal Doctor / Médico Personal
□ Other (please describe) / Otro (describa) _______________

Section 4: Emergency Room (ER) and Hospital History. Please list ONLY those visits within the past year.
Sección 4: Sala de emergencias (ER) e Historia del Hospital. Por favor liste solo las visitas en el ultimo año.

In the last year, have you been to a hospital's Emergency Room (ER)? / En el ultimo año, ¿Cuantas veces as ido a la sala de emergencias de un hospital (ER)? □ **Yes / Sí** □ **No**
If yes, please fill out the information below on when, where an why: / Si es así, por favor llene la siguiente información sobre cuándo, dónde y por qué:

Approximate date of visit / Fecha aproximada de la visita	Hospital	Reason for visit/ Chief Complaint / Motivo de la visita / jefe

In the last year, have you been admitted to a hospital? / En el ultimo año, ¿ha sido admitido en un hospital? □ Yes / Sí □ No
If yes, please fill out the information below on when, where and why: / Si es así, por favor llene la siguiente información sobre cuándo, dónde y por qué:

Approximate date of visit / Fecha aproximada de la visita	Hospital	Reason for hospitalization / Motivo de la hospitalización

Section 5: Access to Health Insurance / Sección 5 : Servicio de Seguro Medico

Do you currently have ANY type of Health Insurance (this includes private insurance, Medicaid, Share of Cost, Medicare, VA, ect) / ¿Actualmente tiene algún tipo de seguro de salud (esto incluye seguro privado, Medicaid, parte del costo, Medicare, VA, ect □ Yes / Sí □ No **If yes, which one? / En caso afirmativo, ¿cuál?** ____________________
Have you recently applied for Medicaid/Medicare? / ¿Ha solicitado recientemente para el Medicaid o Medicare? □ Yes / Sí □ No **If yes, when did you apply? / ¿Cuándo aplico?** ____________________ **What is the status of your application? / ¿Cuál es el estado de su solicitud? □ Approved / Aprobado □ Denied / Negado** **Were you approved for share of cost? / ¿Fue aprobado para parte del costo? □ Yes / Sí □ No** **If yes, for what amount? / Cuanto tiene que pagar?** __________
Have you applied for health insurance through Florida's Health Insurance Marketplace? / ¿Ha solicitado un seguro de salud a través del Seguro de Salud del mercado de la Florida? □ Yes / Sí □ No **If yes, what were the results? / ¿Cuáles fueron los resultados?** ____________________ **If no, why not? / Si no, ¿por qué no?**
If employed, is health insurance offered through your employer? / Si esta trabajando, su empleador le ha ofrecido seguro medico? □ Yes / Sí □ No **If yes, why are you not utilizing the insurance available? / ¿Por qué no utiliza el seguro disponible?**

I verify that the information provided above is correct. I further understand that failure to provide accurate information may result in discharge from Samaritan's Touch Care Center. / Yo verifico que la información proporcionada es correcta. Entiendo además que la ausencia de información precisa puede resultar en la tardanza para no ser elejible en el Centro de Samaritans touch.

Patient Signature / Firma del Paciente: ______________________________ **Date:** ____________

Witness Signature (Staff) / Firma del testigo (personal): ______________________________

SAMARITAN'S TOUCH CARE CENTER
HEALTH HISTORY QUESTIONNAIRE
QUESTIONARIO DE SU HISTORIAL MEDICO

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name / Nombre	☐ M / ☐ F	**DOB / Fecha de nacimiento**
Previous or referring doctor / Nombre de medico anterior	**Date of last physical exam / Fecha del ultimo examen fisico**	

PERSONAL HEALTH HISTORY / HISTORIA MEDICA PERSONAL

MEDICATIONS / MEDICAMENTOS

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS AND VITAMINS / LISTA DE SUS MEDICAMENTOS RECETADOS Y VITAMINAS

Name the Drug / Nombre de medicamentos	Strength / Dosis	Frequency Taken / Frecuencia con la que usted lo toma

ALLERGIES TO MEDICATIONS, FOODS OR INSECT STINGS / ALERGIAS A MEDICAMENTOS O INSECTOS

Check if you are allergic to: ☐ **Shellfish / Mariscos** ☐ **IV Contrast Dye / Yodo** ☐ **Penicillin / Penicilina**

Name the Medication, Food or Insect / Nombre de medicamento, comida o insectos	Reaction you had / Reacion que le produce

Have you ever had a blood transfusion? Ha tenido una transfusion de sangre? ☐ Yes ☐ No

PAST MEDICAL HISTORY / HISTORIAL MEDICO

(PLEASE CIRCLE ALL THAT APPLY)/(HAGA UN CIRCULO SI PADECE DE)

Adrenal Dysfunction Disfunción suprarrenal	Esophageal Dysfunction Disfuncíon del esofago	Pancreatitis
Alzheimers Enfermedad de alzheimer	Fibromyalgia	Periodic Limb Movement Movimiento ocassional de las extremidades
Amyotrophic Lateral Sclerosis Esclerosis lateral amiotrofica	Gallstones Cálculos de la vesícula	Peripheral Artery Disease Enfermeded de la arteria periferica
Anorexia or Bulimia	Gastritis or Gastric Ulcers Ulceras gastricas	Personality Disorder Desorden de personalidad
Anxiety Disorder Trastorno de ansiedad	GERD (reflux problems) Reflejo acido	Pituitary Dysfunction Desorden pituitaria
Arteriovenous Malformations Malformaciones arteriovenosas	Glaucoma	Polycystic Ovarian Syndrome Syndrome de ovario poliquistico
Arthritis Artritis	Heart or Valve Defects Defecto del corazón o de la válvula	Pulmonary Artery Hyper. Hiper arteria pulmonar
Asthma Asmatico	Hemochromatosis	Pulmonary Fibrosis Fibrosis pulmonar
Autoimmune Disease Enfermedad de inmunidad	Hemorrhoids Hemorroides	Radiation Therapy Therapia de radiación
Bipolar Disorder Trastorno bipolar	Hepatitis	Recurrent Infections Infecciones recurrentes
Bleeding Disorder Trastorno de coagulación	HIV or AIDS VIH o SIDA	Restless Leg Syndrome El syndrome de piernas inquietas
Chemotherapy Quimoterapia	Hypertension Presion alta	Sarcoidosis
Cerebrovascular Accident Accidente cerebrovascular	Hyperthyroidism Problemas de tiroides	Schizophrenia Esquizofrenia
Cataracts Cataractas	Hypotension Presion baja	Scleroderma Esclerodermia
Claudication Claudicación	Hypothyroidism Hipotirodismo	Scoliosis
Clotting Disorder Trastorno de coagulación	Inflammatory Bowel Disease Enfermedad intestinal inflamatoria	Seizure Disorder Trastorno Convulsivo
Congenital Heart Defects Defecto congenito del corazón	Irregular Heart Rhythm Ritmo irregular cardiaco	Sickle Cell La enfermedad de celulas falciformes
Coronary Artery Disease Enfermedad de la arteria coronaria	Kyphosis Cifosis	Skin Disorders Desorden de la piel
COPD Enfermedad pulmonar obstructiva congenita	Liver Dysfunction Disfunción del higado	Thalassemia Takasemia
Cystic Fibrosis Fibrosis cistica	Kidney Failure/Dysfunction Insuficiencia renal	Thrombocytopenia Trombocitopenia
Depression Depresión	Malignancy Malignidad	Thrombophilia
Diabetes	Mania	Transfusions Transfusiónes
Dialysis Diálisis	Muscular Dystrophy Distrofia muscular	Tuberculosis
Eclampsia or Pre-Eclampsia	Myocardial Infarction infarto de miocardio	Urinary Retention or Urgency Retension o urgencia urinaria
Endocarditis	Narcolepsy Narcolepsia	Vasculitis
Endometriosis	Obstructive Sleep Apnea Enfermedad del suéno	Visual Defects Defectos visuales
End Stage Renal Disease Enfermedad renal en etapa final	Organ Transplant Transplante de organos	Vocal Cord Dysfunction Disfunción de las cuerdas vocales
Erectile Dysfunction Difunción eréctil	Osteoporosis	

FAMILY HEALTH HISTORY / HISTORIAL MEDICO DE SU FAMILIA

	AGE EDAD	SIGNIFICANT HEALTH PROBLEMS PROBLEMAS DE SALUD
Father **Padre**		
Mother **Madre**		
Sibling **Hermanos**	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	

	AGE EDAD	SIGNIFICANT HEALTH PROBLEMS PROBLEMAS DE SALUD
Children **Niños**	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
Grandmother **Abuela** *Maternal Materna*		
Grandfather **Abuelo** *Maternal Materna*		
Grandmother **Abuela** *Paternal Paterna*		
Grandfather **Abuelo** *Paternal Paterna*		

UNIVERSAL PATIENT AUTHORIZATION FORM FOR FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND QUALITY OF CARE

****PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW****

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): ____

Date of Birth (mm/dd/yyyy): ____

Address, City, State, Zip: ____

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure:

OF WHAT: ALL of my health information including any information about sensitive conditions (if any) (See page 2 for details)

FROM WHOM: ALL information sources (See page 2 for details)

TO WHOM: Specific person(s) or organization(s) permitted to receive my information. (Must be a healthcare provider)

Person/Organization Name: **Samaritan's Touch Care Center** Phone: **(863) 471-1870**

Address: **3015 Herring Ave, Sebring, FL 33870** Fax: **(863) 382-3324**

PURPOSE: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.
EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission.
REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be disclosed to other persons [See page 2 for details].
- I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.
- I have read all pages of this form and agree to the disclosures above from the types of sources listed.

______________________________________ ______________________

Signature of Patient or Patient's Legal Representative Date Signed (mm/dd/yyyy)

______________________________________ Relationship to Patient: ☐ Guardian ☐ Legal Representative

Print Name of Legal Representative Other : ______________________

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

Explanation of Form Florida AHCA FC4200-004

"Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care"
Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"Of What": includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1) All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:
   a) Drug, alcohol, or substance abuse
   b) Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
   c) Sickle cell anemia
   d) Birth control and family planning
   e) Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
   f) Genetic (inherited) diseases or tests
2) Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.
3) Information created before or after the date of this form.

"From Whom" includes:
All information sources including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom":
For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

"Purpose":
Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.
"Revocation": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses by giving written notice. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re-disclosure of Information":
Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form:
If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.

3015 Herring Ave • Sebring, Florida 33870
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Email. WeCare@samaritanstouch.org
Website. www.SamaritansTouch.org

Authorization for Release of Medication

Patient Name: ______________________________ Date of Birth: ______________________________

I hereby authorize release of my medication to the following person(s) in the event that I am unable to pick it up myself:

____

____

____

____

____

____

____

I understand the above person(s) will have to show proper ID to clinical staff before medication is released.

____ ____________________
Patient Signature Date

____ ____________________
Witness Date

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Prescription and Refill Policy

1. Please bring ALL medications to each of your visits. Be sure to include medications from ALL doctors currently treating you. It is essential for STCC's clinical staff to know what medications you are currently taking.

2. Please have ALL ongoing prescriptions refilled as needed. In general your provider will prescribe you enough medication until you are due for your next appointment.

3. If your prescription bottle indicates that you have no refills left. You do not need to contact our office. Contact your pharmacy and they will contact STCC. Do not allow yourself to run out of medication. Plan ahead.

4. Please allow 24 hours for prescription refills to be called into local pharmacies. This does not include weekends and Holidays.

5. STCC's clinical staff will make all reasonable efforts to find the most inexpensive way for patients to acquire their medications, if you are still unable to afford you medication please let STCC staff know so that an alternative can be discussed. It is ultimately the patients responsibility to obtain and take all prescribed medications.

6. For patients that qualify for the Prescription Assistance Program (PAP) additional financial information and signatures may be required. It is your responsibility to provide this information to the dispensary in a timely manner. Failure to do so will cause you to be removed from the PAP program.

7. If you have any questions regarding you medications, please contact the dispensary during regular business hours.

8. STCC does not prescribe OR dispense any controlled substances (narcotics, ect).

Patient Copy

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Written Acknowledgement Receipt
Prescription and Refill Policy

By signing this Written Acknowledgement, I hereby expressly acknowledge my receipt of Samaritan's Touch Care Center's Prescription and Refill Policy.

_________________________ **or** _________________________
Patient's Printed Name | Legal Representative's Printed Name

_________________________ **or** _________________________
Patient's Signature | Legal Representative's Signature

_________________________ _________________________
Date | Date

Preferred Pharmacy: ______________________________

Address: ______________________________

Phone: ______________________________

Acknowledgement NOT obtained because:

______ Patient, or legal representative, declined to accept the Prescription and Refill Policy

______ Patient received Prescription and Refill Policy, but refused to sign Acknowledgement

______ Other (briefly describe) ______________________________

Staff Only

_________________________ _________________________
Employee's Printed Name | Date

____
Employee's Signature

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Statement of Patients Rights and Responsibilities

As a patient of Samaritan's Touch Care Center, you have the right to:

- Be treated with courtesy and respect.
- Know who is providing medical services and who is responsible for your care.
- A prompt and reasonable response to questions and requests.
- Access to care regardless of physical or mental disability, including individuals with HIV infections or who are perceived to have, or be at risk of having, HIV infection.
- Know what patient support services are available in the facility.

A patient is responsible to do the following:

- Provide accurate and complete information about present complaints/medical conditions, and past illnesses.
- Report unexpected changes in his or her condition to the health care provider.
- Follow health care facility rules and regulations affecting patient care and conduct.
- Behave in a respectable manner towards the physician(s), staff and volunteers.
- Be respectful and considerate in regards to the rights and needs of other patients.
- Keep appointments, or cancel at least 48 hours prior to the appointment.
- Report any changes in financial status or family size (including changes in Medicaid, Medicare, or health insurance).
- Provide annual eligibility documents prior to the annual expiration date.

Samaritan's Touch Care Center reserves the right to decline treatment when the patient:

- Failing to cancel or show up to a new patient appointment with STCC.
- Failing to cancel or show up for (3) three primary care appointments at STCC.
- Failing to cancel or show up for (1) one specialist/referral appointment (this includes Specialist, Dental and Lab appointments scheduled on the STCC campus).
- Failing to provide all eligibility documentation before expiration date.
- Failing to report change in financial or health insurance status.
- Failing to treat staff/volunteers/physicians/others with dignity and respect.
- Providing falsified financial or health insurance documentation.
- Failing to follow the treatment plan recommended by the health care provider and taking prescribed medications as directed.

Patient Copy

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Written Acknowledgement Receipt
Statement of Patients Rights and Responsibilities

By initialing next to the statements below, I understand that Samaritan's Touch Care Center (STCC) has the right to decline treatment to me for any of the following reasons.

__________ Failing to cancel or show up to a new patient appointment with STCC.

__________ Failing to cancel or show up for (3) three primary care appointments at STCC.

__________ Failing to cancel or show up for (1) one specialist/referral appointment (this includes Specialist, Dental and Lab appointments scheduled on the STCC campus).

__________ Failing to provide all eligibility documentation before expiration date.

__________ Failing to report change in financial or health insurance status.

__________ Failing to treat staff/volunteers/physicians/others with dignity and respect.

__________ Providing falsified financial or health insurance documentation.

__________ Failing to follow the treatment plan recommended by the health care provider and taking prescribed medications as directed.

By signing this Written Acknowledgement, I hereby expressly acknowledge my receipt of Samaritan's Touch Care Center's Statement of Patient's Rights and Responsibilities.

______________________________ ______________________________
Patient's Printed Name Patients Signature

____
Date

______________________________ ______________________________
Staff Witness Date

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Notice of Patient Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights
You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures
We may use and share your information as we:

- Treat you
- Run our organization
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures
How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Treat you
We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law

- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Patient Copy

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Insert Effective Date of this Notice
- Insert name or title of the privacy official (or other privacy contact) and his/her email address and phone number.
- Insert any special notes that apply to your entity's practices such as "we never market or sell personal information."
- The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, "We will never share any substance abuse treatment records without your written permission." Insert this type of information here. If no laws with greater limits apply to your entity, no information needs to be added.
- If your entity provides patients with access to their health information via the Blue Button protocol, you may want to insert a reference to it here.
- If your entity is part of an OHCA (organized health care arrangement) that has agreed to a joint notice, use this space to inform your patients of how you share information within the OHCA (such as for treatment, payment, and operations related to the OHCA). Also, describe the other entities covered by this notice and their service locations. For example, "This notice applies to Grace Community Hospitals and Emergency Services Incorporated which operate the emergency services within all Grace hospitals in the greater Dayton area."

SAMARITAN'S
TOUCH CARE CENTER

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Written Acknowledgement Receipt
Notice of Privacy Practices

By signing this Written Acknowledgement, I hereby expressly acknowledge my receipt of Samaritan's Touch Care Center's Notice of Patient Privacy Practices.

______________________	or	______________________
Patient's Printed Name		Legal Representative's Printed Name
______________________	or	______________________
Patient's Signature		Legal Representative's Signature
______________________		______________________
Date		Date

Acknowledgement NOT obtained because:

______ Patient, or legal representative, declined to accept Notice of Patient Privacy Practices

______ Patient received Notice of Patient Privacy Practices, but refused to sign Acknowledgement

______ Other (briefly describe) ____

Staff Only

______________________	______________________
Employee Printed Name	Date
______________________	
Employee Signature	

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Patient Responsibility for Emergency Department/Room Visits

I, ______________________________________, acknowledge that any/all Emergency Department/Room visits
Patient
are NOT a covered service provided by Samaritan's Touch Care Center. I acknowledge that I am financially responsible for the full balance or to make any necessary payment arrangements, with the said hospital for any/all services rendered by Florida Hospital Heartland's or Highlands Regional Medical Center's Emergency Department/Room.

Patient Signature: ______________________________________ Date: ______________________

Staff Signature: ______________________________________ Date: ______________________

Responsabilidad del Paciente Por visitas a la sala de emergencia

Yo, ______________________________________, acepto que las visitas a la sala de emergencias no estan cubiertas
Paciente
bajo los servicios del Samaritans Touch Care Center. Yo Acepto que sera mi responsabilidad de pagar todas las cuentas financieras con el hospital o con la sala de emergencias del Florida Hospital o Highlands Regional Hospital el cuarto de emergencias.

Firma del paciente: ______________________________________ Fecha: ______________________

Firma del personal: ______________________________________ Fecha: ______________________