UCF Health
COLLEGE OF MEDICINE PRACTICE

Patient Name: ______________________________

Date of Birth: ______________________________

HEALTH HISTORY QUESTIONNAIRE

Primary Care Physician: ______________________________

Other physicians you currently see: ______________________________

Emergency Phone #:____________________Contact Person/Relationship: ____________________

Reason for the Visit: ______________________________

Please list your medications and respective dosages in the chart below and provide the reason why you take it.
Please list all vitamins, over the counter medications, herbal medicine, etc.

Medication	Dose (units or mg)	Frequency	Reason/Prescribed Date

Preferred Pharmacy
Name:______________________________
Address:______________________________Zip Code:____________________

Chronic Medical Problem List	Date Diagnosed	Chronic Medical Problem List	Date Diagnosed

Allergies	
Substance or Medication	Reaction

Patient Name: ________________________________ **Date of Birth:** ______________________________

Past Surgical History

Procedures | Surgeries | Hospitalization	Date

Social History

Alcohol: ☐ Never ☐ Current ☐ Past

For Current or Past use: ☐ Beer ☐ Wine ☐ Hard Liquor

Amount/Day:_____________Number of years:_________

Tobacco (cigarettes, chewing, etc.): ☐ Never ☐ Current ☐ Past - *Year Quit*_____________

For Current or Past use:

Amount/Day:____________Number of years:_________

Employment: ☐ Currently ☐ Disabled ☐ Part time ☐ Retired ☐ Student ☐ Unemployed ☐ Other

Occupation: _____________

Education: ☐ High School ☐ College ☐ ___________

Marital Status: ☐ Single ☐ Married ☐ Life Partner ☐ Separated ☐ Divorced ☐ Widowed

Exercise: ☐ No ☐ Yes Times per week: __________

Duration (average number of minutes):__________

Family History

Yes	No	Condition	Family Member(s)
☐	☐	Alzheimer's / Dementia	
☐	☐	Breast Cancer	
☐	☐	Colon Cancer	
☐	☐	Depression	
☐	☐	Diabetes	
☐	☐	Elevated Cholesterol	
☐	☐	Heart Disease/Stroke	
☐	☐	High Blood Pressure	
☐	☐	Ovarian/Prostate Cancer	
☐	☐	Skin Cancer	
☐	☐	Thyroid Disease	
☐	☐	Other	

Vaccination History

Vaccine	Date
Influenza (Flu Shot)	
Tetanus (Td/Tdap)	
Shingles (Zostavax)	
Pneumonia	
Hepatitis B series	
Meningitis	
HPV/Gardasil series	
Other	

Preventative Health Screening

Screening	Date
Last Colonoscopy	
Last Mammogram	
Last Pap Smear	
Bone Density/DEXA	

Do you have an Advance Directive? ☐ No ☐ Yes *Date*: __________

If No, would you like to receive information? ☐ Yes ☐No

I certify that my *Health History Questionnaire* is accurate. I further certify that I have read and agree to the *Patient Policies and Procedures & Notice of Privacy Practices* (rev. 122009.01) located at **UCF Health Website** (www.ucfhealth.com/privacy) including:
1) *Payment and Billing Policy & Procedures*;
2) Disclosure of Information for Reimbursement & Assignment of Benefits; 3) *Notice of Privacy Practices (HIPAA)*

______________________________________ ______________________

Patient Signature *(or caregiver/ parent/guardian if minor)* **Date**

If signed by the Patient's Representative, please print name and describe relationship to patient or other authority to act:

______________________________________ ______________________

Name Relationship to Patient

UCF Health

COLLEGE OF MEDICINE PRACTICE

PATIENT REGISTRATION FORM

Today's Date: ________________________ Are you a current UCF COM student? ☐Yes ☐No

Patient's Last Name:________________________First Name:______________________Middle Name:______________

Birth Date:_______/______/_______ Gender: ☐ Male ☐Female ☐Visually Impaired ☐Hearing Impaired

Address:____City: __________________________

State:__________ZIP Code: _______________

Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Partner

Spouse/Partner's Name: ____

Primary Language______________________Race__________________________Ethnicity______________________

Parent / Guardian Name if Patient is a minor:

Last Name:____________________________First Name:___________________________Middle Name:__________________

Address if different:____________________________________City:__________________State__________Zip ____________

The following information will assist us in communicating with you about your care while protecting your confidentiality. When we return calls and an answering machine picks up, we do not leave a message if the recorded message on the machine does not list the patient name. Information will also not be left with an unauthorized person who may answer the telephone.

Preferred Method(s) of Contact:

Home Phone:_____________________Mobile Phone:______________________Work Phone: ________________________

*Email: ____

*Email used for appointment reminders only.

May we speak with someone other than you when confirming your appointment?

☐ Do not leave me a message or release information to anyone. Please speak to me directly.

☐ Yes – Please speak only to the person listed below.

Name:____Relationship to Patient: _________________

Updated: 6/15/17

UCF Health

Emergency Contact Information

Name:_______________________________Relationship_______________Phone___________

Name:_______________________________Relationship_______________Phone___________

Name:_______________________________Relationship_______________Phone___________

I, ___________________________(patient's name) certify that the above information is my personal information and has not been fraudulently derived. I understand that is it is my responsibility to notify UCF Health of any changes to the above.

____ ____________________

Signature of Patient or Patient's Authorized Representative Date

**If signed by the patient's representative, please print name and describe relationship to patient or other authority to act:

____ _______________________________

Name Relationship to Patient

How Did You Hear About Us?

1. How did you hear about us? Please check **THE PRIMARY** way you heard about us.

_____ Friend or Family
_____ Physician Referral
_____ Insurance Company
_____ UCF Student Health
_____ Information by Mail
_____ Television
_____ Radio
_____Printed Article
_____Email
_____Internet
_____Social Media
_____Corporate Event
_____Community Event
_____Event at UCF Health
_____ Other (Please explain): ____

2. What is your zip code? __________________

3. If you would like to receive periodic health information, please give us your name and email:

Name:____________________________________Email: _____________________________________

UCF Health
COLLEGE OF MEDICINE PRACTICE

UCF Health
COLLEGE OF MEDICINE PRACTICE

CONSENT TO TREATMENT AND FINANCIAL AGREEMENT

Patient's Name: ____

Date of Birth:_______/______/______ Date of Visit:______/______/______

I. **Authorization for Routine Diagnostic Procedure and Treatment** – I hereby consent to such diagnostic procedures and treatments including physiological, psychological and behavioral health services, which in the judgment of my health care provider may be considered necessary or advisable. I recognize that the UCF Health physicians and staff are employees of a health care teaching and research institution and that my treatment and care may be observed and in some instances aided by students and residents under appropriate supervision. I consent to UCF Health taking photographs of me in the course of and related to my treatment and I consent to the use of such photographs and my medical data for educational purposes by UCF Health. I also hereby authorize UCF Health to retain, preserve and use for scientific, educational or research purpose, or dispose of as they might deem fit, any specimens or tissues taken from my body.

II. **Assignment of Benefits and Responsibilities for Payment** – I hereby assign to UCF Health 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 any health care services I receive for, related to, or connected with this visit or treatment by UCF Health (past, present, or future). I agree to be personally responsible for payment of any health care services that are not covered by third party payors, including, but not limited to, non-covered or out-of-network services, deductibles, co-insurance, and/or co-payments. Third party payors include, but are not limited to, coverage available from: Medicare, Medicaid, Tri-care, 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.

III. **Psychology/Psychiatry Services Records** – I hereby understand and agree that my medical record containing psychiatry, psychological and behavioral health information may be available to physicians, nurses, medical assistants, students and other staff at UCF Health, and discussion of my case may occur between a student, a resident, and his/her supervisor alone or in small groups of students or residents for whom the supervisor has responsibility.

IV. **Prescription History** – I understand that performing a medication reconciliation in order to prevent adverse drug interactions and overdose is a critical component to my care. By signing this form, I authorize my provider to query and review my medication fill history including drug, dose, form, strength, prescribing provider, and pharmacy.

V. **Use and sharing of health information**– By signing below as Patient/Representative I hereby authorize UCF Health and its physicians providing services during treatment and 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, genetic diseases and test results, sickle cell anemia, tuberculosis, birth control, abortion, sexually transmitted diseases, and HIV/AIDS tests) and other information as may be required for my treatment and quality assurance, to secure payment for charges incurred by me or on my behalf, to any UCF Health affiliated facility or provider, to other treating providers (including health care providers outside UCF Health), to third party payors for which I have assigned benefits for my treatment and care, to any sponsors that UCF Health may later obtain to contribute payment for my treatment and care, and to any and all regulatory and/or accrediting organizations as necessary for UCF Health to maintain its licensure and accredited status as well as for participation in utilization review and Healthcare Effectiveness Data and

Information Set (HEDIS) reporting to insurance companies. I also authorize release of any information to county, state or federal public health agencies, disease registries, and as required by law.

VI. **Exchange of Health Information** - UCF Health participates in the Commonwell platform, which makes health information available as needed by persons providing medical care, enabling the patient to receive more informed and better coordinated care and to avoid unnecessary duplication of tests, inconvenience and unnecessary cost. By signing below as Patient/Representative, I agree to UCF Health exchanging my health information with other health care providers treating me. This information may include sensitive health information related to mental health conditions and treatment (including psychological and psychiatric care), sexually transmitted diseases, birth control, abortion, substance (drug and alcohol) abuse and treatment, genetic diseases and genetic test results, sickle cell anemia, tuberculosis and HIV/AIDS. I understand I am not required to consent to this exchange of health information as a condition of treatment. I understand that I can opt out of this exchange of health information or revoke my consent effective for future health information by contacting the Health Information Specialist for UCF Health at 407-266-3627 to make that election.

VII. **Workers Compensation** – I hereby authorize UCF Health to release information from and/or copies of my medical records related to the workplace injury or illness, to the employer, workers' compensation insurance carrier, or their attorneys.

VIII. **Guarantor Agreement** – By signing below as Patient/Representative, I hereby agree that all charges connected with the treatment, not covered by any insurance, sponsorship or other third party coverage I may have, are due and payable by me at the time of the visit. 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 plan, I will be responsible for any balance due. The charges I agree to pay are those listed in the current Billing Charge Fee Schedules unless otherwise established by an applicable agreement. I hereby acknowledge that, UCF Health has agreed to bill my insurance or other third party carrier as a courtesy and that UCF Health has the right to demand payment in full from me at any time prior to full payment from any third party payor. If an overdue account is referred for 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 charges for the services provided to me.

IX. **Lien on Third Party Liability Proceeds** – If my treatment is due to an accident or injury, UCF Health shall have a lien upon the proceeds of any cause of action, suit, claim, counterclaim, or demand accruing to me or my legal representative as a result of such accident or injury, in order to recover payment for all charges of 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 UCF Health may be entitled by law.

X. **Agreement to Pay for Professional Component and Other Pathology Services** – Some services such as laboratory and imaging are provided by third party organizations that are not affiliated with UCF Health and I understand I may receive separate bills for these services directly from the organization providing the service, and I agree to be financially responsible for such bills.

By signing below, I acknowledge that I have read this Consent to Treatment and Financial Agreement, that I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction**,** that this form has been fully explained to me and that I understand all of the information in this **Consent to Treatment and Financial Agreement**..

____ _______________

Signature of Patient or Authorized Representative **Date**

If signed by the Patient's Representative, please print name and describe relationship to patient or other authority to act:

______________________________________ _______________

Name **Relationship or Authority**

Witness Signature____**Date**_____________

Print Name ________________________

_____**My initials here mean that I have received a copy of this form for my record**

COPIES OF THIS STATEMENT SHALL BE AS VALID AS THE ORIGINAL.
ORIGINAL SIGNATURES ON FILE WITH UCF HEALTH.

UCF Health
COLLEGE OF MEDICINE PRACTICE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Name of Patient: ____

Date of Birth: __________________________

I have received a copy of UCF Health's *Notice of Privacy Practices* available at ucfhealth.com/privacy or at the front desk. I understand that UCF Health has the right to change its *Notice of Privacy Practices* from time to time and that I may contact UCF Health at any time to obtain a current copy of the *Notice of Privacy Practices*.

I am Consenting to the disclosure of my protected health information to the following individuals.

Name:______________________________________ Relationship:__________________________

Name:______________________________________ Relationship:__________________________

Name:______________________________________ Relationship:__________________________

___________________________________ ______________________________

Signature of Patient or Patient's Authorized Representative — Date

If signed by the Patient's Representative, please print name and describe relationship to patient or other authority to act:

__________________________________ ______________________________

Name — Relationship to Patient

For Office Use Only – To be completed only if no signature is obtained.

I have made a good faith effort to obtain the patient's signature on this form, but was not able to do for the following reason:

❑ Patient (or Patient's Representative) refused to sign.

❑ Other: ____

Signature of UCF Health representative: ___________________________________
Date: ________________

Updated 11/21/13

UCF ✦ Health
College of Medicine Practice

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your health information; to provide you this detailed Notice of our legal duties and privacy practices relating to your health information; to notify you following a breach of the privacy or security of your unsecured protected health information and to abide by the terms of the Notice that are currently in effect. The effective date of this Notice is September 23, 2013.

I. USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The following lists various ways in which we may use or disclose your health information for purposes of treatment, payment and health care operations.

For Treatment. We will use and disclose your health information in providing you with treatment and services and coordinating your care and may disclose information to other providers involved in your care. Your health information may be used by doctors involved in your care and by nurses, medical assistants and technologists and other care givers as well as by physical therapists, pharmacists, suppliers of medical equipment or other persons involved in your care. For example, Health physicians and medical assistants will discuss coordination of your care.

For Payment. We may use and disclose your health information for billing and payment purposes. We may disclose your health information to your representative, or to an insurance or managed care company, Medicare, Medicaid or another third party payor. For example, we may contact Medicare or your health plan to confirm your coverage, to request prior approval for services that will be provided to you, and/or for reimbursement of care provided to you.

For Health Care Operations. We may use and disclose your health information as necessary for health care operations, such as accreditation, management, personnel evaluation, education and training and to monitor our quality of care. We may disclose your health information to another healthcare-related entity with which you have or had a relationship if that entity requests your information for certain of its health care operations or health care fraud and abuse detection or compliance activities. For example, health information of many patients may be combined and analyzed for purposes such as evaluating and improving quality of care.

II. SPECIFIC USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

The following lists various ways in which we may use or disclose your health information.

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose health information about you to a family member, close personal friend or other person you identify, including clergy, who is involved in your care.

Emergencies. We may use or disclose your health information as necessary in emergency treatment situations.

As Required By Law. We may use or disclose your health information when required by law to do so.

Business Associates. We may disclose your protected health information to a contractor or business associate who needs the information to perform services for UCF Health. Our contractors and business associates are committed to preserving the confidentiality of this information.

Public Health Activities. We may disclose your health information for public health activities. These activities may include, for example, reporting to a public health authority for preventing or controlling disease, injury or disability; reporting child abuse or neglect or reporting births and deaths.

Reporting Victims of Abuse, Neglect or Domestic Violence. If we believe that you have been a victim of abuse, neglect or domestic violence, we may use and disclose your health information to notify a government authority, if authorized by law or if you agree to the report.

Health Oversight Activities. We may disclose your health information to a health oversight agency for oversight activities authorized by law, such as audits, investigations, inspections, licensure, disciplinary actions or for activities involving government oversight of the health care system or facility.

To Avert a Serious Threat to Health or Safety. When necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person, we may use or disclose health information, limiting disclosures to someone able to help lessen or prevent the threatened harm.

Judicial and Administrative Proceedings. We may disclose your health information in response to a court or administrative order. We also may disclose information in response to a subpoena, discovery request or other lawful process so long as the party seeking the information demonstrates reasonable efforts were made by such party to contact you about the request or to obtain a qualified protective order in accordance with 45 CFR section 164.512 (e)(1)(v).

Law Enforcement. We may disclose your health information for certain law enforcement purposes, including, for example, to comply with reporting requirements; to comply with a court order, warrant, or similar legal process; or to answer certain requests for information concerning crimes.

Research. We may use or disclose your health information for research purposes if the privacy aspects of the research have been reviewed and approved, if the researcher is collecting information in preparing a research protocol, if the research occurs after your death, or if you authorize the use or disclosure.

Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations. We may release your health information to a coroner, medical examiner, funeral director or, if you are an organ donor, to an organization involved in the donation of organs and tissue.

Disaster Relief. We may disclose health information about you to a disaster relief organization.

Military, Veterans and other Specific Government Functions. If you are a member of the armed forces, we may use and disclose your health information as required by military command authorities. We may disclose health information for national security purposes or as needed to protect the President of the United States or certain other officials or to conduct certain special investigations.

Workers' Compensation. We may use or disclose your health information to comply with laws relating to workers' compensation or similar programs.

Inmates/Law Enforcement Custody. If you are under the custody of a law enforcement official or a correctional institution, we may disclose your health information to the institution or official for certain purposes including the health and safety of you and others.

Appointment Reminders. We may use or disclose health information to remind you about appointments.

Treatment Alternatives and Health-Related Benefits and Services. We may use or disclose your health information to inform you about treatment alternatives and health-related benefits and services that may be of interest to you.

Fundraising. We may, with your permission, contact you for fundraising for the benefit of UCF Health and you have a right to opt out of receiving such communications.

III. USES AND DISCLOSURES WITH YOUR AUTHORIZATION

Except as described in this Notice, we will use and disclose your health information only with your written Authorization (such as, for certain types of marketing, sale of your protected health information). For example, we will only use and disclose your health information for the purposes of marketing with your written Authorization. Further, most psychotherapy notes may not be disclosed for any purpose, including treatment, payment or health care operations, without your written Authorization. You may revoke an Authorization in writing at any time. If you revoke an Authorization, we will no longer use or disclose your health information for the purposes covered by that Authorization, except where we have already relied on the Authorization.

IV. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Listed below are your rights regarding your health information. Each of these rights is subject to certain requirements, limitations and exceptions. Exercise of these rights may require submitting a written request to the UCF Health. At your request, UCF Health will supply you with the appropriate form to complete. You have the right to:

Request Restrictions. You have the right to request restrictions on our use or disclosure of your health information for treatment, payment, or health care operations. You also have the right to request restrictions on the health information we disclose about you to a family member, friend or other person who is involved in your care or the payment for your care.

We are not required to agree to your requested restriction EXCEPT (i) if you request that we not disclose certain medical information to your health insurer and that medical information relates to a health care product or service for which we otherwise have received payment in full from you or on your behalf (from someone other than your health insurer), then we must agree to the request unless the disclosure is otherwise required by law and (ii) if you are competent you may restrict disclosures to family members or friends. If we do agree to accept your requested restriction, we will comply with your request except as needed to provide you emergency treatment.

Access to Personal Health Information. You have the right to inspect and obtain a copy of your clinical or billing records or other written information that may be used to make decisions about your care, subject to some exceptions. Your request must be made in writing. In most cases we may charge a reasonable fee for our costs in copying and mailing your requested information. You may request an electronic copy of any of your clinical or billing records that are maintained electronically.

We may deny your request to inspect or receive copies in certain circumstances. If you are denied access to health information, in some cases you have a right to request review of the denial. This review would be performed by a licensed health care professional designated by UCF Health who did not participate in the decision to deny.

Request Amendment. You have the right to request amendment of your health information maintained by UCF Health for as long as the information is kept by or for UCF Health. Your request must be made in writing and must state the reason for the requested amendment.

We may deny your request for amendment if the information (a) was not created by UCF Health, unless the originator of the information is no longer available to act on your request; (b) is not part of the health information maintained by or for UCF Health; (c) is not part of the information to which you have a right of access; or (d) is already accurate and complete, as determined by UCF Health.

If we deny your request for amendment, we will give you a written denial including the reasons for the denial and the right to submit a written statement disagreeing with the denial and how you may file such a statement. In addition, you may request that UCF Health provide your request for amendment and the denial with any future disclosures of the protected health information that is the subject of the amendment, in lieu of submitting the statement of disagreement.

Request an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your health information. This is a listing of disclosures made by UCF Health or by others on behalf of UCF Health, but does not include disclosures for treatment, payment and health care operations (except where such disclosures are through an electronic health record). , disclosure made pursuant to your Authorization, and certain other exceptions.

To request an accounting of disclosures, you must submit a request in writing, stating a specific time period. The first accounting provided within a 12-month period will be free; for further requests, we may charge you our costs.

Request a Paper Copy of This Notice. You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time. In addition, you may obtain a copy of this Notice at our website, www.ucfhealth.com.

Request Confidential Communications. You have the right to request that we communicate with you concerning your health matters in a certain manner. We will accommodate your reasonable requests.

V. FOR FURTHER INFORMATION OR TO FILE A COMPLAINT

If you have any questions about this Notice or would like further information concerning your privacy rights, please contact the UCF College of Medicine HIPAA Privacy Officer at 407-266-1000.

If you believe that your privacy rights have been violated, you may file a complaint in writing with UCF College of Medicine/UCF Health and/or the Office of Civil Rights in the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint.

To file a complaint with UCF Health, contact the UCF College of Medicine HIPAA Privacy Officer at 407-266-1000.

VI. CHANGES TO THIS NOTICE

We reserve the right to change this Notice and to make the revised or new Notice provisions effective for all health information already received and maintained by UCF Health as well as for all health information we receive in the future. We will provide a copy of the revised Notice upon request or you can access it from the UCF Health website at www.ucfhealth.com.