ACORN MEDICAL CLINIC Financial Screening

Date:_____

Adult Patient or Parent

Last Name:_____ First Name:_____

Mailing Address_____ Home Phone: (____) _____

City: _____ State:_____ Work Phone: (____) _____

Zip Code:_____ County:_____ Sex:_____ Race:_____

Insurance ID#_____ Group #_____ Marital Status _____

Social Sec#:_____ Date of Birth_____

Emergency Contact Name and Phone _____

If patient is a child:

Child Last Name: _____ First Name:_____

Social Security#_____ Date of Birth _____

Insurance ID#_____ Sex _____ Race _____

Are you a Veteran? Yes or No **Are you a Meridian Behavioral Healthcare Patient? Yes or No**

Financial Screening

Proof of income must be provided to qualify for the sliding fee scale

How many people in household? _____ How many children under the age of 18? _____

List names of all members of your household._____

_____

If you or any other family member has received income from any of the following sources in the last month please write the amount in the space provided.

Employment / Unemployment:_____ Child support / Alimony:_____

Social security /SSI / Disability:_____ AFDC / Food stamps:_____

TOTAL HOUSEHOLD INCOME:_____

I certify that the above information is complete and true._____

Patient/Guardian Signature

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby request and authorize ACORN Medical Clinic
23320 N. State Rd 235
Brooker, FL 32622

From:_____
_____

The following information from _____(dates)

____All Medical Information and Reports
____Prenatal Medical Records
____Physical Examination Reports
____Laboratory Reports
____Immunizations
____X-Ray Reports
____Other (specify) _____
_____

For the Medical Records of: _____

Soc. Sec.#_____ Date of Birth:_____

Effective:_____

Through:_____

_____
Signature of Patient

_____
Date

_____
Witness

Please fax records to ACORN Clinic 352-485-2927
If you have any questions please call 352-485-1133

Thank you

Volunteer Practitioners Providing Rural Health Care Since 1974

ACORN CLINIC

23320 N SR 235

Brooker, FL 32622

Medical 352-485-1133 Dental 352-485-2772

Important Notices to Patients

1. Medical Care and Treatment Provided by Practitioners Who Are Not Employed by ACORN

   Please know that, with rare exceptions, the medical care and treatment you receive at ACORN Clinic is not being provided by ACORN employees. It is provided by University of Florida employees or agents, Santa Fe Community College employees or agents, or volunteer community practitioners.

_____Initial

2. Limited Liability for Medical Care and Treatment provided by University of Florida Providers

   As stated above, medical care and treatment at ACORN Medical Clinic may be provided by doctors, residents and students and other health care providers who are the employees or agents of the University of Florida Board of Trustees ("University of Florida"), not ACORN. These health care providers are not employees or agents of ACORN, they provide medical care and treatment at ACORN through an agreement. Liability arising from the provision of care and treatment by the University of Florida employees or agents is limited to $100,000 per claim by any one person, and to $200,000 for all claims arising out of the same incident or occurrence, as provided by Florida law.

_____Initial

3. Prescription of Controlled Substances at ACORN

   ACORN will not prescribe controlled substances which include narcotics, pain medications, valium and other anxiety medications for chronic conditions. In the event that you need these medications on a regular basis, you will be required to find another provider.

_____Initial

4. Tobacco-Free Facility Policy

   In the spirit of promoting health and wellness, the facility and grounds of ACORN Clinic, including all parking areas, are to be tobacco-free. All employees, volunteers, patients and visitors are expected to comply by refraining from use of any and all tobacco products on the premises. For those patients who express an inability to forego the use of tobacco while waiting to be seen and/or during the appointment sessions, the Clinic will provide the minimum amount of nicotine gum pieces required to assist the patient in refraining from use until s/he is able to leave the property (approximately 1 piece per half-hour, barring any contradictions). Patients interested in smoking cessation can inquire about programs available.

_____Initial

5. Agreement to Pay for Medical Services and Treatment at ACORN

   ACORN Clinic is committed to providing low-cost health care services to our community, especially those who have limited access to care. However, we incur expenses and our patients are responsible for paying their charges. I agree to pay my charges at ACORN Clinic.

_____Initial

6. Photo/Video Release

I authorize ACORN Clinic to use my photograph/video for various reasons, including but not limited to Education and Grant funding.

I further acknowledge that my participation is voluntary.

_____Initial

7. Patient Portal

ACORN Clinic now offers a web portal for our patients to access their medical information. If you would like to participate, please include your email address below: _____

8. Consent for Treatment

I, _____, hereby authorize ACORN Clinic and its agents to provide me with care, treatment, and procedures ordered by my health care provider and as requested by me or my legal representative, as it pertains to my health care.

By my signature below, I acknowledge that I have read and understand the notices above:

_____ _____

Patient/Guardian Signature Date

Volunteer Practitioners Providing Rural Health since 1974

ACORN CLINIC

Medical Patient Responsibility Agreement

1. Proof of Income

   ACORN Clinic has sliding scale fees for our uninsured patients. Patients must provide proof of their household income to be charged lower fees for their health care. Patients will be billed at the highest sliding scale fee until proof of income is provided. Patient assistance medications (available at very low costs) cannot be provided without proof of income.

2. Payment is Due at time Services are Provided
   Co-pays, deductibles, office visit fees, medication charges, and lab charges are due on the day of service. We accept personal checks, credit/debit cards, or cash.

3. Payment Arrangement for Balance Due
   If a patient cannot pay their entire bill at the time of service, a payment plan can be made. A monthly amount that is affordable to the patient and proportionate to the amount owed will be agreed upon in writing between the patient and ACORN Clinic. If an acceptable payment plan cannot be made, no further appointments will be scheduled and the patient may be discharged from the ACORN Medical Clinic. If one payment is missed the patient will be warned in writing. If two payments are missed at any time during the arrangement period the patient will be discharged from the clinic. Once discharged, the patient must pay the full amount owed before being accepted back into the practice and before any future appointment can be made. If at any time the payment plan needs to be changed, the patient must request this in writing to ACORN Clinic.

4. Appointment Confirmation (revised May , 2017)
   We **MUST** have a confirmation to hold your appointment. We will call everyone before their appointment. You **MUST** confirm your appointment no later than the day before appointment. If we do not hear from you we will cancel your appointment to allow someone else to take the appointment. If you are hard to reach or do not have a phone, etc. you **MUST** call us.

5. No Show
   Appointments should be cancelled or rescheduled at least 24 hours in advance. A "no show" is when a patient misses an appointment without calling us in advance. If a patient does not follow the cancellation policy or has three "no shows" in a 12 month period the patient may receive a letter dismissing them from ACORN Medical Clinic for one year. If at the end of one year the patient wants to come back to ACORN Medical Clinic the patient will be accepted back, as long as any outstanding bill is paid.

6. Patient Discharge (revised May 1, 2017)
   A patient may be discharged from treatment at ACORN Medical Clinic with 30 days' notice for the follow reasons: 1) three no shows for appointments 2) patient being disrespectful or aggressive with staff/providers. During the 30 days, the patient may be seen for medical care and/or medications. During that time it is expected that the patient will find another provider for medical care and they will no longer be seen at the end of the 30 days.

7. Adherence to Treatment
   Health Care is a partnership between the patient and their healthcare provider. It is the provider's responsibility to discuss options for care and to recommend preferred plans of care to each patient. It is the patients' responsibility to follow the agreed upon plan of care. If a patient does not follow the plan of care after discussion with the provider, the provider may discharge the patient from the ACORN Medical Clinic.

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

_____ _____

Patient or Guardian Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee Signature Date

Authorization to Release Medical Information to Individuals/Family Members

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your healthcare provider or staff of ACORN Medical Clinic to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ **I DO NOT authorize** ACORN Medical Clinic to release any information concerning my medical care to Individuals/Family Members.

_____ **I do authorize** ACORN Medical Clinic to release all information concerning my medical care to the following individuals:

_____	_____
Name	Phone Number
_____	_____
Name	Phone Number
_____	_____
Name	Phone Number
_____	_____
Patient Signature	Patient Phone Number

_____

Print Patient Name Date of Birth Social Security Number

_____	_____
Witness Signature	Date

Our office is online!

Request Appointments

E-mail a Doctor or Nurse

Get Your Lab Results

Provide us with your email address to start managing your healthcare from the Web.

Name _____

Email _____

Doctor _____

ACORN CLINIC myHealthStory

We are collecting your email address for our records, and will use it to issue you an invitation to enroll in our online communication service. Enrollment is optional. We will not disclose your address to others without your prior written consent.

www.acornclinic.org

Name: _____ **Date**_____

Best Contact Number to Reach You_____

1. Do you have a problem with reliable transportation for medical or dental appointments? ☐ YES ☐ NO
2. Do you have a safe, affordable place to live? ☐ YES ☐ NO
3. Does anyone take your money without permission? ☐ YES ☐ NO
4. Has anyone at home hit you or tried to injure you in anyway? ☐ YES ☐ NO
5. Do you have trouble getting enough nutritious food for you and your family? ☐ YES ☐ NO
6. Do you have any problems getting and taking your medications as prescribed? ☐ YES ☐ NO
7. Have you had any recent falls? ☐ YES ☐ NO
8. Do you need any home modifications for safety such as grab bars, ramp, stair railings? ☐ YES ☐ NO
9. Do you use tobacco, and if so, would you like to talk to the Social Worker about getting help to quit? ☐ YES ☐ NO
10. Do you need help to get a hearing aid? ☐ YES ☐ NO
11. Do you need help to get eyeglasses? ☐ YES ☐ NO
12. Do you get help at Meridian Behavioral Services? ☐ YES ☐ NO
13. Are you a Veteran ☐ YES ☐ NO

Rev 03/13/2018

ACORN CLINIC

ADULT HEALTH HISTORY
(Use for ages 21 and over)

Your answers on this form will help your provider understand your medical concerns and conditions. If you are comfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. Thank you.

Patient Name:_____ Today's Date:_____
Date of Birth:_____ Age:_____ How would you rate your general health? O Excellent O Good O Fair O Poor
Main reason for today's visit:_____
Other concerns I would like to discuss today:_____

REVIEW OF SYSTEMS Please check any CURRENT symptoms you have.

General
___ Recent fevers/sweats
___ Unexplained weight loss/gain
___ Unexplained tiredness/weakness

Eyes
___ Change in vision

Ears/Nose/Throat/Mouth
___ Difficulty hearing/ringing in ears
___ Hay fever/allergies/congestion
___ Trouble swallowing

Heart/Cardiovascular
___ Chest pains/discomfort
___ Palpitations
___ Short of breath with activity

Breast
___ Breast lump
___ Nipple discharge

Lungs/Respiratory
___ Cough/wheeze
___ Coughing up blood

Gastrointestinal
___ Heartburn/reflux
___ Blood or change in bowel movements
___ Nausea/vomiting/diarrhea
___ Pain in abdomen

Genitourinary
___ Painful/bloody urination
___ Leaking urine/weak urine stream
___ Nighttime urination
___ Discharge: penis or vagina
___ Unusual vaginal bleeding
___ Concern with sexual function

Musculoskeletal
___ Muscle/joint pain
___ Recent back pain

Skin
___ Rash
___ New or change in mole

Neurological
___ Headaches
___ Memory loss
___ Fainting/falling

Psychiatric/Emotional
___ Anxiety/stress
___ Sleep problems

Blood/Lymph
___ Unexplained lumps
___ Easy bruising/bleeding

Endocrine
___ Cold/heat sensitive
___ Increased thirst/ appetite

In the past month, have you had little interest in doing things, or felt down, depressed or hopeless? O Yes O No

CURRENT MEDICATIONS Please list all medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication	Dose (mg/pill)	Times/day	Medication	Dose (mg/pill)	Times/day

ALLERGIES or reactions to medications:_____

Date of your most recent IMMUNIZATIONS: Influenza (flu shot)___ Pneumovax (pneumonia)___ Tetanus (Td)___ Tdap (tetanus & pertussis)___
Hepatitis A___ Hepatitis B___ MMR___ Meningitis___

Signature of person completing this form:_____
Reviewed by provider:_____

ADULT HEALTH HISTORY

Patient Name:_____ Date:_____

PERSONAL MEDICAL HISTORY: Please note if you have any of the following medical problems

___ Heart disease
___ Specific type:_____
___ Heart attack
___ Asthma/lung disease
___ High Blood Pressure
___ Diabetes
___ Cancer (type)_____
___ Other (Specify)_____
___ High cholesterol
___ Thyroid problem
___ Kidney disease
___ Birth defect

SURGICAL HISTORY: Please list all prior operations (with details)

FAMILY HISTORY: Please note family members (mother, father, sister, brother, aunt, uncle, grandparent)

Alcoholism_____
Cancer (type)_____
Heart disease_____
Depression/suicide_____
Genetic disorders_____
Diabetes_____
High Cholesterol_____
High blood pressure_____
Stoke_____
Bleeding/clotting disorder_____
Asthma/COPD_____
Other_____

SOCIAL HISTORY:

Tobacco use:
O Never O Quit date:_____
O Current smoker: packs/day____ # of years____
Other tobacco: O Pipe O Cigar O Snuff O Chew
Plan to quit? O Now O Sometime later O No/never

Alcohol Use:
Do you or any household members drink alcohol?
O No O If Yes, who?_____ O Socially
# of drinks/week_____

Drug Use/Addiction:
Do you or any household members use drugs?
O No O If Yes, who?_____
Name of drug?_____
Does anyone in your household have an addiction to a drug or prescription medication?
O No O If Yes, who?_____
Name of drug/medication_____

OTHER CONCERNS:
Caffeine Use: O None O Coffee/tea/soda____cups/day
Weight: Are you satisfied with your weight? O No O Yes
Diet: How do you rate your diet? O Good O Fair O Poor
Exercise: Do you exercise regulary? O No O Yes, how often?_____
What kind of exercise?_____ Minutes per day?_____
If you do not exercise, why?_____
Safety: Do you use a bike/motorcycle helmet? O NA O No O Yes
Do you regularly wear seatbelts? O No O Yes
Is there violence in the home? O No O Yes
Have you ever been abused? O No O Yes

Sexual Activity:
Sexually active? O No O Yes O Not currently
Current sex partner(s) is/are: O Male O Female
Birth control method_____ O None needed
Have you ever had any sexual transmitted diseases? (STD's) O No O Yes,_____
Interested in being screened for STD's? O No O Yes

Do you have a completed living will or power of attorney for health care? O No O Yes

Signature of person completing this form:_____
Reviewed by provider:_____

ADULT HEALTH HISTORY

Patient Name: _____ Date: _____

HEALTH MAINTENANCE/SCREENING TESTS:

General:

Yearly dental visits? O No O Yes

Date of last dental checkup? _____ O Unknown

Do you take Calcium? O No O Yes

Do you take Aspirin? O No O Yes

Have you had any of the following tests? Select each box that applies and enter date of most recent test.

	O Lipid (cholesterol) test	Date: _____	Abnormal? O No O Yes
	O Sigmoidoscopy or O Colonoscopy	Date: _____	Abnormal? O No O Yes
	O Stool for occult blood (3 samples)	Date: _____	Abnormal? O No O Yes
Men:	O PSA (prostate)	Date: _____	Abnormal? O No O Yes
Women:	O Mammogram	Date: _____	Abnormal? O No O Yes
	O Clinical breast exam	Date: _____	Abnormal? O No O Yes
	O Pap smear	Date: _____	Abnormal? O No O Yes
	O DEXA scan/bone density	Date: _____	Abnormal? O No O Yes

Age at start of periods: _____ First day of last menstrual period: _____ Age at end of periods: _____

Do you have problems with your period or birth control? O No O Yes. _____

List number of pregnancies: _____ Deliveries: _____ Abortions/miscarriages: _____ Living children/ages: _____

If post menopause or over age 50, do you take:

Calcium? O No O Yes Estrogen? O No O Yes Progesterone? O No O Yes

SOCIAL/ECONOMIC:

Occupation: _____ Employer: _____

Highest level of education: _____ Marital status: O Single O Married/partnered O Divorced O Widowed O Other

Spouse/Partner's name: _____ Number of children (ages): _____

Who lives at home with you? _____

Signature of person completing this form: _____

Reviewed by Provider: _____

Patient Privacy Policy

JOINT NOTICE OF PRIVACY PRACTICES AND NOTICE OF ORGANIZED HEALTH CARE ARRANGEMENT

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

If you have any questions about this Notice, please contact either the HIPAA Officer for ACORN Clinic or at the contact information listed below:

- ACORN Clinic Privacy Office
  352-485-1133 x 11

OUR LEGAL DUTY TO PROTECT HEALTH INFORMATION ABOUT YOU

We understand your health information is personal and we are committed to protecting it. We create a record of the care and services you receive at ACORN Clinic to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by ACORN Clinic, whether made by ACORN Clinic personnel, ACORN Clinic faculty, staff, students, or your personal provider. This Notice describes how we may use and disclose your health information, and provides examples where necessary. This Notice also describes your rights regarding your health information.

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

CHANGES TO THIS NOTICE

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

NOTICE OF ORGANIZED HEALTH CARE ARRANGEMENT

ACORN Clinic has agreed as permitted by law, to share your health information among themselves for purposes of treatment, payment or health care operations. This arrangement enables us to better address your health care needs in the integrated setting found within ACORN Clinic care providers.

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

We may use and disclose your health information to provide medical treatment to you and to coordinate or manage your health care and related services. This may include communicating with

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

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

- **Individuals Involved in Your Care or Payment for Your Care.** We may use or disclose information to a family member, legal representative, or other persons involved with or responsible for your care or the payment of your care.
- **Emergency Circumstances and Disaster Relief.** We may disclose information about you to an agency assisting in a disaster relief effort so that your family can be notified of your location and general condition. Even if you object, we may still share the health information about you, if necessary for emergency circumstances.

USES AND DISCLOSURES OF HEALTH INFORMATION THAT REQUIRE YOUR WRITTEN PERMISSION

Other uses and disclosures of health information not covered by this notice or applicable law will be made only with your written permission. If you provide permission to use or disclose health information, you may revoke that permission at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your revocation. We are unable to take back any disclosures already made with your permission.
We will not use or disclose your protected health information for marketing purposes, nor will we sell your protected health information without your written permission.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

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

Right to See and Obtain Copies of your Health Information

You have the right to see and obtain copies of health information used to make decisions about your care. Usually, this includes medical and billing records, and excludes psychotherapy notes.

To view and copy your health information, you must submit your written request on the appropriate form to Clinic. We may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to see and obtain copies of your health information in certain very limited circumstances. You have the right to appeal the denial.

Right to Amend

If you think that your health and billing information is incorrect or incomplete, you may ask us to correct it. We may deny your request if:

1. The information was not created by us;
2. The information is not part of the records used to make decisions about your care;
3. We believe the information is correct and complete; or
4. You do not have the right to review parts of the medical record under certain circumstances.

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

If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, as needed, including persons you name who have received information about you and who need the amendment. Your request must be in writing and include an explanation of your reason(s)

ACORN Clinic
Laboratory Fee Schedule

	Test Name		Acorn Fee
	Amylase		10.00
	ANA		29.00
	B-12, Folate		
	B-12, Vitamin		10.00
	Basic Metabolic Panel (BMP)		6.00
	CBC with diff & platelet count		6.00
	Chem 21		
	Chlamydia / Gonorrhea		44.00
	Comprehensive Metabolic Panel		6.00
	CPK, Total		17.00
	C- Reactive Protein		15.00
	Culture, Urine		10.00
	D- Vitamin		42.00
	Ferritin		7.00
	Folate,Serum		8.00
	Follicle Stimulating Hormone (FSH)		15.00
	Free T4		9.00
	Free T3		22.00
	Glucose		6.00
	Hemoglobin A1C		6.00
	Hepatic Function Panel (LFT)		8.00
	24 Hour Urine /Creatine		14.00
	Insulin		11.00
	Iron		7.00
	Lipase		12.00
	Lipid Profile		11.00
	Micro Albumin, Urine		17.00
	Magnesium		11.00
	Pap Smear		40.00
	Pathology		60.00
	Potassium		5.00
	PTH , INTACT		37.00
	Prostate Specific Antigen (PSA)		12.00
	Micro Albumin , Urine		17.00
	Protein, Urine		17.00
	Prothrombin Time (INR)		8.00
	Renal Function Panel		6.00
	Rheumatoid Arthritus (RA)		12.00
	Sedrate (ESR)		7.00
	SGPT (ALT)		4.00
	Urine Culture		10.00
	Wound/ Throat Culture		20.00
	Testostrone		73.00
	TIBC		7.00
	TSH		8.00
	Uric Acid		6.00
	Urinalysis		5.00