TGH CANCER INSTITUTE | CCSF CANCER CENTER OF SOUTH FLORIDA

Reason for Visit:_____ **Date:**_____

Patient Name:_____ _____ _____ _____
Last *First* *Maiden* *Middle*

Social Security Number:_____–_____–_____ **Sex**: ☐ Male ☐ Female ☐ Other:_____

Date of Birth:_____/_____/_____ **Language**:_____

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

Ethnicity: ☐ Non-Hispanic ☐ Hispanic **Race**:_____

Religion:_____ ☐ Decline to Share

Mailing Address:

Address:_____ Zip:_____

City:_____ State:_____

Home Phone:_____ Cell Phone:_____

If no phone, Contact Name:_____

Emergency Contacts: (Contacts)

Name:_____

Address:_____ Zip:_____

City:_____ State:_____

Phone:_____ Relationship to Patient:_____

Employer:

Employer's Name:_____

Address:_____ Zip:_____

City:_____ State:_____

Person Responsible for Bill: (Guarantor) _____

Name of Primary Insurance:_____

Subscriber's Name:_____ Date of Birth:_____/_____/_____

Subscriber's SS#:_____–_____–_____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Secondary Insurance (if applicable):_____

Subscriber's Name:_____ Date of Birth: _____/_____/_____

Subscriber's SS#:_____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Communication Preference: ☐ *Email:_____ ☐ SMS (Text): _____

*Patient consent is required to receive email communications from CCSF. All emails sent by CCSF to patients shall be encrypted.

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

Patient Name: _____Date of Birth: _____

Other Doctor Information			
Referring doctor:		**Phone:**	
Primary/Family doctor:		**Phone:**	
Radiation Oncologist Name:		**Phone:**	
Surgeon Name:		**Phone:**	

Preferred Pharmacy	
Pharmacy Name:	
Phone:	
Address:	

Please answer the following questions, so that we may provide you excellent care and ensure that you receive appropriate referrals to available resources. All answers are confidential and will be reviewed by your doctor or nurse.

1. Do you refuse to accept any blood and/or blood products? ☐ No ☐ Yes
2. Do you need any assistance with walking? ☐ No ☐ Yes
3. Do you live alone? ☐ No ☐ Yes
4. Are you currently homeless or do you have housing problems? ☐ No ☐ Yes
5. Do you have trouble getting to places such as the doctor's office or pharmacy? ☐ No ☐ Yes
6. Have you had a fall in the past year or since your last visit? ☐ No ☐ Yes
7. Are you currently in a drug or alcohol treatment program? ☐ No ☐ Yes
8. Have you ever experienced abuse or violence? ☐ No ☐ Yes
9. Are you currently afraid of someone in your life, or is someone being abusive or violent toward you? ☐ No ☐ Yes
10. Have you recently lost a loved one? ☐ No ☐ Yes
11. Do you have little interest or pleasure in doing things? ☐ No ☐ Yes
12. Do you feel down, depressed, or hopeless? ☐ No ☐ Yes

Nutrition Screen

1. Are you on a special diet or tube feeding? ☐ No ☐ Yes
2. Have you lost more than 5-10 pounds unintentionally in the last month? ☐ No ☐ Yes
3. Do you have difficulty swallowing food and/or beverages? ☐ No ☐ Yes

Patient Information

Ambulatory Social Assessment

Family Care Pre-visit Assessment

Dear Patients:
To help expedite your visit, please complete health questionnaire by checking YES or NO to each applicable medical or surgical diagnosis.

Name:_____ **Date of Birth**:_____

Drug and/or other Allergies:_____

Medical History

Anemia	☐ Yes ☐ No	GERD	☐ Yes ☐ No	PPD positive	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Rheumatoid arthritis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Seasonal/Environ allergies	☐ Yes ☐ No
Bipolar disorder	☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Blood transfusion	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Sickle cell anemia	☐ Yes ☐ No
Burn injury	☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No	Sleep apnea	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hyperlipidemia	☐ Yes ☐ No	Sleep disorder/insomnia	☐ Yes ☐ No
Carpal tunnel	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No	Spina bifida	☐ Yes ☐ No
CHF	☐ Yes ☐ No	Irritable bowel syndrome	☐ Yes ☐ No	STD	☐ Yes ☐ No
Chronic pain	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
COPD	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No	Substance abuse	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Low back pain	☐ Yes ☐ No	Thyroid disease	☐ Yes ☐ No
Diabetes mellitus	☐ Yes ☐ No	Myocardial infarction	☐ Yes ☐ No	Trauma/Violence	☐ Yes ☐ No
DVT or blood clot	☐ Yes ☐ No	Neuropathy	☐ Yes ☐ No		
Emphysema	☐ Yes ☐ No	Osteoarthritis	☐ Yes ☐ No		
Fibromyalgia	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No		

Other illnesses:_____

Surgical History – Male

Appendectomy	☐ Yes ☐ No	Eye surgery	☐ Yes ☐ No	Spine surgery	☐ Yes ☐ No
Brain surgery	☐ Yes ☐ No	Fracture surgery	☐ Yes ☐ No	Valve replacement	☐ Yes ☐ No
CABG	☐ Yes ☐ No	Hernia repair	☐ Yes ☐ No	Vasectomy	☐ Yes ☐ No
Cholecystectomy	☐ Yes ☐ No	Joint replacement	☐ Yes ☐ No		
Colon surgery	☐ Yes ☐ No	Prostate surgery	☐ Yes ☐ No		
Cosmetic surgery	☐ Yes ☐ No	Small intestine surgery	☐ Yes ☐ No		

Other surgeries:_____

Surgical History – Female

Appendectomy	☐ Yes ☐ No	Cosmetic surgery	☐ Yes ☐ No	Joint replacement	☐ Yes ☐ No
Brain surgery	☐ Yes ☐ No	C-section	☐ Yes ☐ No	Small intestine surgery	☐ Yes ☐ No
Breast surgery	☐ Yes ☐ No	Eye surgery	☐ Yes ☐ No	Spine surgery	☐ Yes ☐ No
CABG	☐ Yes ☐ No	Fracture surgery	☐ Yes ☐ No	Tubal ligation	☐ Yes ☐ No
Cholecystectomy	☐ Yes ☐ No	Hernia repair	☐ Yes ☐ No	Valve replacement	☐ Yes ☐ No
Colon surgery	☐ Yes ☐ No	Hysterectomy	☐ Yes ☐ No		

Other surgeries:_____

Pregnancy history: Number of times pregnant: _____ Premature births:_____ Miscarriages:_____
Abortions:_____ Living children:_____

Hospitalizations

Reason:_____ Date:_____

Reason:_____ Date:_____

Family History illnesses

Mother:_____

Father:_____

Siblings:_____

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Live: ☐ Alone ☐ With spouse/partner ☐ Children ☐ Other adult ☐ Facility

Other:_____

Do you smoke: ☐ Yes ☐ No How many years:_____

Have you ever smoked: ☐ Yes ☐ No Quit date:_____

If yes, how many packs per day:_____

Alcohol use: ☐ Yes ☐ No How frequent:_____ Type:_____

Recreational Drug Use: ☐ Yes ☐ No How frequent:_____ Type:_____

Medications you are taking

Medication Name	How often	Dosage

Immunizations

Pneumonia: ☐ Yes ☐ No Date:_____ Tetanus: ☐ Yes ☐ No Date:_____

Polio: ☐ Yes ☐ No Date:_____ MMR: ☐ Yes ☐ No Date:_____

Flu: ☐ Yes ☐ No Date:_____ Hepatitis B: ☐ Yes ☐ No Date:_____

Others:_____

Health Maintenance

Colonoscopy: ☐ Yes ☐ No Date:_____ Mammogram: ☐ Yes ☐ No Date:_____

Eye exam: ☐ Yes ☐ No Date:_____ Dexa scan: ☐ Yes ☐ No Date:_____

Pap smear: ☐ Yes ☐ No Date:_____

Your Care Team: Write the names of your Specialists below and the reasons you see them:

Dr. Name:_____ Reason:_____

Dr. Name:_____ Reason:_____

Dr. Name:_____ Reason:_____

Dr. Name:_____ Reason:_____

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Patient Name _____ Date _____

Do you have a **personal** history of the following?

Ashkenazi Jewish ancestry	☐ Yes	☐ No
Breast Cancer diagnosed at age 49 or younger or diagnosed with triple negative disease at any age	☐ Yes	☐ No
Ovarian Cancer	☐ Yes	☐ No
Pancreatic Cancer	☐ Yes	☐ No
Metastatic Prostate Cancer	☐ Yes	☐ No
Colorectal Cancer diagnosed at age 50 or younger	☐ Yes	☐ No
Gastric Cancer diagnosed at age 40 or younger	☐ Yes	☐ No
Uterine Cancer diagnosed at age 50 or younger	☐ Yes	☐ No
Melanoma diagnosed at least three times	☐ Yes	☐ No

Do you have a **family** history of the following?

Breast Cancer diagnosed at age 49 or younger?	☐ Yes	☐ No
Ovarian Cancer diagnosed at any age?	☐ Yes	☐ No
Pancreatic Cancer diagnosed at any age?	☐ Yes	☐ No
Metastatic Prostate Cancer diagnosed at any age?	☐ Yes	☐ No
Colorectal Cancer diagnosed at age 49 or younger?	☐ Yes	☐ No
Uterine Cancer diagnosed at age 49 or younger?	☐ Yes	☐ No

Patient Signature _____ Date _____ Time _____

For Office Use Only:

If patient has selected yes to any of the above questions and accepts genetic testing, please place an Ambulatory Referral to Genetic Counseling (ref127).

Cancer Care Screening

CCSF CANCER CENTER OF SOUTH FLORIDA

Patient Name: _____
Last *First* *Maiden* *Middle*

Social Security Number:_____-_____-_____ Date of Birth:_____/_____/_____ Age:_____

ADULT

You may release my medical information to: (Not for Medical Records release of info)

Name and relation	*Name and relation*	*Name and relation*
Phone #	*Phone #*	*Phone #*

Signature of Patient / Legal Guardian *Date*

PEDIATRIC

I, _____, biological parent / legal guardian of _____ (D.O.B. _____) hereby give my permission to examine, treat, etc. the above child without my being present. This permission is only intended to facilitate my child's healthcare if I am unable to be with my child. I give this permission to the following to bring my child to appointments and leave a message about my child:

Name	Relation
Name	Relation
Name	Relation

☐ **I decline permission to examine, treat, etc. the above child without my being present.**

I also understand that adolescents have certain legal rights of confidentiality, legally, and that I should get his/her permission to get information from the physicians.

Signature of Parent / Legal Guardian _____ Date _____

Witness _____ Date _____

Care Permission Form
Ambulatory Services

CANCER CENTER OF SOUTH FLORIDA

Coordination of Benefits

Some patients are covered by more than one health insurance policy. Most health insurance carriers coordinate benefits. This means both companies share the responsibility of covering the patient's medical expenses, paying no more than 100% of the billed charges. This avoids duplication of payments, which would result in higher premium rates.

It is also important that we identify your health insurance coverage.

This form will provide us with the information required to coordinate payment with your other insurance company, if applicable.

1. Do you or any member of your family have insurance coverage for services being rendered today?
   ☐ Yes ☐ No
2. Do you or any member of your family have a secondary health insurance?
   ☐ Yes ☐ No

   If you answered "Yes" to this question, please provide both the name of the secondary health insurance company and the policy number below.

   Insurance company name:_____

   Policy number:_____
3. If your treatment is a result of an injury or accident, are you aware of any coverage that has been made available to cover the cost of your care? ☐ Yes ☐ No

   If you answered "Yes" to this question, please provide both the name of the additional health insurance company and the policy number below.

   Insurance company name:_____

   Policy number:_____

Please present insurance card(s) for electronic scanning purposes to ensure correct billing and coordination.

If your insurance changes at any point during your stay, you agree to notify Cancer Center of South Florida of the changes in your coverage.

Please note that if you provide insurance information to Cancer Center of South Florida more than one (1) business day after you receive service, your insurance carrier may deny payment for no authorization.

Your signature below indicates that you have provided complete and accurate information.

Patient signature:_____ Date:_____

Print patient name:_____

Authorized representative signature:_____ Date:_____

Print authorized representative name:_____

Relationship to patient:_____

Authorization for Request of Medical Record Information and Full Disclosure of Health Information for Treatment & Quality of Care

Patient name: _____ _____ _____ _____ _____
Last First Middle Birth Date Age

Address: _____ _____ _____ _____ ____/____/____
Street City State Zip Social Security Number

The purpose for disclosing this information is 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.

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

1. All my health information in both paper and electronic format regarding my health history, treatment, hospitalizations, test, and outpatient care. This information includes but is not limited to:
   - Drug, alcohol, or substance abuse.
   - Psychological, psychiatric or other mental impairments.
   - Records which indicate the presence of communicable disease test for or records related to HIV or sexually transmitted diseases.
   - Genetic diseases or test.
2. This information may be shared with other hospitals, clinics, pharmacies, mental health facilities, state registries, health information exchanges (HIE), regional health information organizations (RHIO), accountable care organizations (ACO) and other federal or state programs or agencies. Information may be shared with health care providers which would include physicians, nurses and other medical staff involved in my care, and demographics about the encounter of care rendered.
3. In Addition:
   - I authorize the use of a copy of this form for disclosure of the information described above.

I have read all of this form and agree to the disclosures above.

I hereby grant Cancer Center of South Florida and its affiliates to share my records with:_____

Signature:_____ **Date:**_____ **Time:**_____

I also hereby authorize and request:

_____
Name of Health Care Facility

_____ _____ _____ _____
Address City State Zip

_____ _____ _____
City State Zip

to release medical, psychiatric, alcohol, AND/OR substance abuse information contained in subject's medical records for the purpose of continued care to: Cancer Center of South Florida, 1450 CentrePark Blvd, Suite 165, West Palm Beach 33401, Fax: 561-253-3985 (Attn: Medical Records). Please contact (561) 253-3980 with any questions.

The foregoing is subject to such limitations as indicated below:

☐ 1. Confined to records regarding admission and treatment for the following medical condition or injury:

_____

☐ 2. Covering records for the period from_____ to _____

☐ 3. Confined to the following specific information:_____

_____

☐ 4. No limitations placed on dates, history of illness, or diagnostic and therapeutic information, including any treatment for alcohol and drug abuse as protected by Federal Regulation 42CFR, Part II; psychiatric/psychological information and AIDS-related information including testing, FS 394.459,490.32 and / or 90.503, 381,609.

This authorization / permission form will remain in effect for life or the day I withdraw my permission.

Signature:_____ **Date:**_____ **Time:**_____

Welcome to CCSF. Thank you for choosing our facility for your care. The information that is stated below will assist you in answering some commonly asked questions. If you have additional questions or concerns, please ask our staff.

CCSF Cancer Care • (561) 253-3980

Office Policies

Change in Information: Please notify us immediately of any changes in your insurance, address, or phone number. **Your doctor may need to contact you for various reasons.**

Arrival Time:
New patients: The time that you are told is the arrival time, not appointment time. New patients are asked to allow 30 minutes prior to that time for processing of new patient paperwork. If you arrive later than your scheduled time, you may run the risk of the doctor not seeing you and having to reschedule.
Returning patients: Please arrive according to your given arrival time. If you arrive 15 minutes after your arrival time, you may be asked to reschedule since you are considered late.

Wait Time: There may be occasions when the doctor / nurse needs additional time with a patient. Please be assured that when it is your turn to see the doctor, adequate time will be given to you as well. You may bring a snack and drink while you are waiting. This is recommended if you have a condition in which you may need a snack. (To maintain a clean environment, no soda or candy machines are available.)

Multiple Missed Appointments: This could severely affect our ability to provide your care. Multiple missed appointments may result in our request for you to seek care elsewhere. If you are not able to keep your appointment, please call (561) 253-3980 to reschedule. It is your responsibility to cancel or reschedule appointments at least 24 hours in advance.

Medications: Bring your current medications with you. This will greatly help in your treatment.

Co-Pays: Co-Pays are due at the time of service. There is a charge on all returned checks. We accept credit cards, cash, and personal checks. Larger denomination bills may not be accepted. **We do not accept walk-in patients.**

Forms: Please allow 5-7 business days for the Physician to complete any forms you are requesting.

We appreciate your patience and understanding!

I have read and understand the above:_____ Date:_____
Signature of Patient/Guardian

Office Policies

Cancer Care

Rev. 01/2024

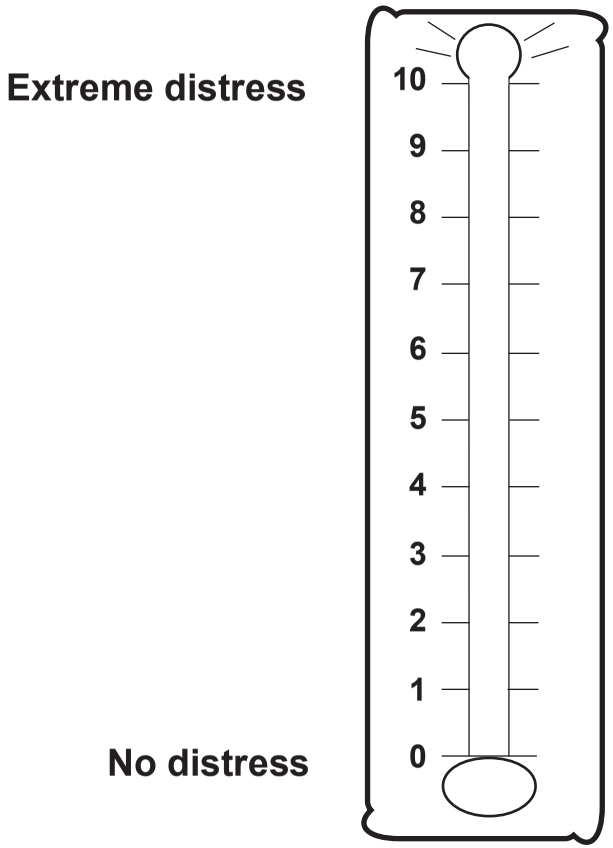
National Comprehensive Cancer Network®

NCCN Distress Thermometer and Problem List for Patients

NCCN DISTRESS THERMOMETER

Distress is an unpleasant experience of a mental, physical, social, or spiritual nature. It can affect the way you think, feel, or act. Distress may make it harder to cope with having cancer, its symptoms, or its treatment.

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week including today.



PROBLEM LIST

Please indicate if any of the following has been a problem for you in the past week including today.
Be sure to check YES or NO for each.

YES	NO	Practical Problems
❑	❑	Child care
❑	❑	Food
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
❑	❑	Treatment decisions

YES	NO	Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family health issues

YES	NO	Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities

YES	NO	Spiritual/religious concerns
❑	❑	

YES	NO	Physical Problems
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urination
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Substance use
❑	❑	Tingling in hands/feet

Other Problems: _____

_____

Section A: Authorization for Diagnostic Procedures and Medical Treatment

PATIENT CONSENT AND AUTHORIZATION FOR TREATMENT

I. Consent: I, on behalf of myself or as an authorized person for any other individual, consent to all treatment recommended by my physician which may include emergency services or treatment, diagnostic testing, imaging and laboratory procedures, medical or surgical treatment, anesthesia, and other treatments recommended for me while a patient at Cancer Center of South Florida ("CCSF"). These treatments may involve the risk of injury or death. I acknowledge that no one at CCSF has made any guarantees to me regardingthe treatments or care I may receive while at CCSF.

II. Treatment at an Academic Medical Center: CCSF is in cooperation with Tampa General Hospital ("TGH"). TGH, in conjunction with the University of South Florida ("USF"), is an academic medical center. As a teaching and research facility, my treatment and care at CCSF, in cooperation with TGH, may be provided by USF medical students and residents under the supervision of a USF physician, or may be observed by others who are not licensed healthcare providers.

III. I acknowledge that CCSF is not responsible for the medical care or treatment provided by USF physicians or any other independent contractor physicians. I also understand that I have a right to choose the physician who directs my care, provided that the physician of my choice has appropriate privileges at CCSF. I agree that I will be relying on my physicians and other healthcare providers, including medical students and residents and their employers ("Healthcare Providers") to provide me with appropriate care and treatment. I will not look to CCSF to fulfill those duties or obligations. I hereby release CCSF from any and all liability for the acts or omissions of any Healthcare Provider not employed by CCSF.

IV. Research and Education: I understand while a patient at CCSF, I may be contacted for the purposes of research and/or clinical educational settings; however, I am not obligated to participate in any research and/or agree to treatment in any clinical educational setting. I understand that photographs, videos and other images may be taken for identification, as part of or to document my care, or for educational purposes. I consent to the use of all my medical data and any non-identifiable photographs for educational and/or research purposes. I authorize CCSF to retain, preserve and use for scientific, educational, commercial or research purposes, or to dispose of, any specimens, tissues or organs taken from my body during the course of treatment. I will not share in any proceeds that may generated therefrom.

V. Advance Directives: I have received information about the CCSF's policy on Living Wills and the designation of a health care surrogate. Additional information on these subjects are available upon my request.

VI. Reporting Requirements: If my test results reveal a condition that is reportable to a government agency, including the local health department, by applicable Florida or federal law, CCSF may release my personal contact information along with positive results to the applicable agencies as required by law.

VII. Tobacco Free Campus. CCSF prohibits the use of tobacco products, electronic cigarettes, and vaping devices anywhere within the hospital or its campus. If I choose to engage in this prohibited activity, I understand I am removing myself from CCSF's care and may be discharged. I assume all risks associated with this prohibited activity, which may include medical complications, injury, and/or death. I hereby release CCSF from any and all liability associated with this prohibited activity.

VIII. Illegal Items. I will not bring any weapon, explosive device, illegal drug or substance, alcoholic beverage, or other contraband to CCSF. If found in my or my guests' possession or control, CCSF shall take any action it deems reasonable, including alerting the police, confiscating and disposing of any contraband items, which may be delivered to law enforcement, or excluding certain persons from CCSF and its affiliated properties. You acknowledge that CCSF may search any items brought into any part of the facility, including a patient room, if CCSF reasonably believes that potentially harmful contraband is present.

Section B:

ASSIGNMENT OF PROCEEDS, AUTHORIZATION TO RELEASE INFORMATION AND GUARANTOR AGREEMENT

I. Medicare/Medicare Advantage/Medicaid/TRICARE: I certify that the information given by me to apply for payment under any Title of the Social Security Act is correct. I also certify that I have complied, and will continue to comply, with all laws applicable to any such payments, including any obligation to protect the interests of the payors of any such payments as may be required or necessary. I authorize any holder of medical or other information about me to release to the Social Security Administration, and its intermediaries or carriers any information related to any claim. I request that payment of authorized benefits be made on my behalf to CCSF or Healthcare Provider, as applicable, by any applicable payor. I assign the benefits payable for CCSF or Healthcare Provider services to CCSF or the Healthcare Provider furnishing the services (as applicable), and I authorize CCSF or suchHealthcare Provider to submit a claim to Medicare, Medicare Advantage, Medicaid or TRICARE for payment. I understand that I am responsible for any health insurance deductibles, co-insurance, co-payments, and all non- covered charges. CCSF has provided me the Medicare notice entitled "An Important Message from Medicare," and I am personally responsible for any non-covered services, deductibles, co-payments and/or co-insurances.

II. Assignment of Insurance Benefits and Proceeds: I assign to CCSF or the Healthcare Provider, as applicable, all of my rights and interests to any benefits or other recovery of any type whatsoever receivable by me or on my behalf that may be due and payable to me by any governmental payor, insurance company (including automobile liability, liability, personal injury protection, medical payments, uninsured or underinsured motor vehicle benefits), health maintenance organization, managed care company, self-funded plan, plan sponsor, plan fiduciary, and their agents (each, a "Health Plan") as well as from any settlements/judgments/verdicts, or any other third-party payor for any costs incurred in receiving healthcare goods or services from CCSF or any Healthcare Provider (as applicable). I authorize direct payment to CCSF and/or any Healthcare Provider (as applicable) of all such benefits or recovery. I authorize and designate CCSF and/or the Healthcare Provider (as applicable) as my agent and authorized representative to pursue any appeal of any claim under this assignment, including to receive all information, documentation, and/or notifications related to my claim, and pursue all legal and equitable claims in CCSF's or Healthcare Provider's (as applicable) name or in my name, including claims for attorneys' fees and costs, that I may have against my Health Plan arising from payment denials or reductions, improper claims administration and processing, or other misconduct. The authorizations in this section are irrevocable.

III. Release of Medical Information: I authorize CCSF to release any and all information, including copies of medical records in electronic or paper form, to any person or entity for the purposes of treatment, health care operations, and payment, including releasing information to agents or employees of my insurance company or other payers. I specifically authorize the release of

information pertaining to any psychiatric care and treatment (but not "psychotherapy notes" as that term is defined by law), mental health care and treatment, HIV serology results, alcohol treatment, and substance abuse care and treatment pertaining to me. If I have or receive an implantable device, unless I strike through this sentence, I consent to the release of my Social Security Number to the device manufacturer. I authorize and allow for any exchange of personal health information as required by law and the disclosure of all elements of data to be exchanged. I consent to the transfer of electronic data between CCSF and its business associates and other health care facilities for the continuity of care and outpatient services. I understand that my physician will be sent an automatic notification of my admission. For a more detailed description of uses and disclosures for treatment, payment or normal healthcare operations, please review the Notice of Privacy Practices provided to you.

IV. Valuables/Belongings Release: By signing in the space as Patient or Guarantor (party responsible for payment of account), I acknowledge I have the opportunity to use a safe at CCSF. Any valuables, belongings or money that remain with me are not CCSF's responsibility if they are lost or stolen. This includes clothing, jewelry, eyeglasses, dentures, hearing aids and other personal belongings, including cell phones, and other electronics.

V. Payment Agreement: I agree all charges are due at the time of discharge for inpatient services and at the time of service for outpatient services. I am responsible for the full charges of the services I receive, and I am personally responsible for any unpaid charges if third-party source(s) do not pay in full or otherwise reject payment of my claim. Unless otherwise agreed in writing, I agree any partial payments received by CCSF or any Healthcare Provider do not constitute "accord and satisfaction" or otherwise effect a settlement or resolve an existing dispute as to amounts due and owing by me to CCSF or any Healthcare Provider (as applicable). I further acknowledge CCSF and Healthcare Provider do not accept reference-based pricing from myHealth Plan. I agree that if I receive payment directly from any other third- party source for the charges associated with my treatment, it is my responsibility to immediately pay such payments to CCSF or any Healthcare Provider (as applicable).

I understand that any bill I receive from CCSF is separate from the Healthcare Providers' bills I may receive, which may include invoices from InPhyNet Contracting Services, Inc., Radiology Associates of Florida, USF, University Medical Services Association, Ruffolo Hooper and Associates or other providers, none of which are included in the CCSF bill. CCSF makes no guarantee that any Healthcare Providers are contracted with my health insurance provider. I acknowledge that if I obtain laboratory or diagnostic testing, any bills I receive for such services are separate from CCSF.

In accordance with Florida Statute 395.301, I acknowledge that I have been informed of my right to an itemized bill. Please call (561-844-7291) after your discharge to request a copy of your bill. I understand that I am responsible to pay for any private room differential in the event that my insurer does not cover this expense.

If I fail to pay any obligation to CCSF which is determined to be my personal responsibility according to law, I will be responsible for all costs of collection, which may include attorneys' fees and court costs, and include pre-judgment and post-judgment interest at the rate set forth in the Florida Statutes.

VI. Financial Information. I acknowledge that during the course of my admission, stay, and after discharge, I may be asked to provide financial information for the purposes of determining eligibility for uncompensated or discounted care, applying for government programs, instituting payment arrangements, or for other related purposes. I hereby certify that such information provided by me will be provided in good faith and will be accurate to the best of my knowledge. I hereby authorize CCSF to obtain credit reports concerning me from one or more credit bureaus. I understand CCSF may obtain credit reports concerning me without my written authorization under some circumstances, as permitted by law. I hereby authorize CCSF to provide information about me (whether received from me or from a credit bureau) to third parties for business-related purposes, including billing, collection, instituting payment arrangements, and determining eligibility for uncompensated care, discounted care, and/or government programs.

VII. Communications. I authorize CCSF and/or its business associates to contact me via telephone, cellular phone, and/or electronic mail, which may include pre-recorded messages, auto-dialers, artificial voice messages, text messages, and/or other forms of automated/electronic communication at any telephone number I provide. I understand that electronic mail communications can be intercepted in transmission or misdirected and my use of electronic mail communication to CCSF indicates I acknowledge and accept the possible risks associated with such communication. To the extent I have provided CCSF a cellular phone number or e-mail address, I am consenting for CCSF and/or its business associates to contact me via such cellular phone or e-mail address, with communications that may include information about my account and efforts to collect any outstanding invoices. This authorization will remain in effect until five (5) business days after I rescind this authorization, which must be done in a writing provided to CCSF at 1450 CentrePark Blvd, Suite 165, West Palm Beach 33401, Attention: Patient Financial Services.

I have received CCSF's Notice of Privacy Practices. _____
Please initial here.

I have received CCSF's Rights and Responsibilities. _____
Please initial here.

Should you need additional information on any matter contained concerning your rights or responsibilities as a patient, please contact the CCSF's Administration at (561) 253-3980.

_____ _____
Signature Date

_____
Print Name

_____ _____
Witness Date

As: ☐ Patient ☐ Patient's Spouse ☐ Parent or Guardian
☐ Other/Specify Relationship:_____

Certification and Authorization for Diagnostic Procedures and Medical Treatment