Eligibility Form

□ Initial Intake □ Re-Enrollment

Section 1: Please complete the following information.

Full Legal Name:	**Today's Date:**
Home address: **How long have you been a resident of Orange County?**	
Email: (for appointment reminders and health related topics related to your care):	
Phone Numbers Home phone: _____ Cell phone: _____ Work phone: _____	Check ONE that you want us to call first O Prefer we call this first? O Prefer we call this first? O Prefer we call this first?

Section 2: Patient Profile

Gender: O Female O Male	**Social Security Number (required):**	**Do you consider yourself**: O Not Hispanic/Latino O Hispanic/Latino
Marital Status: O Single O Married O Separated O Divorced O Widowed	**Date of Birth (required):** **How were you referred to Grace?**	**Race:** O White O Black/African American O Asian O Native Hawaiian O Other Pacific Islander O American Indian/Alaskan Native O Other
Preferred Language: O English O Spanish O Haitian Creole O Other, I speak… _____	**What is the highest level of education you completed?** O Not yet completed high school or GED O Completed High School or GED O Associates degree or higher (from college/university) completed	**Where do you currently live?** O Own or rent an apartment/house O Staying with friends/relatives O Shelter O Transitional housing O Staying on the street, in car, in woods, etc.
Are you a veteran? O No O Yes	**Are you a member of a religious organization** (e.g. church, temple, etc)? O No O Yes, I attend _____	

FOR OFFICE USE ONLY .

Proof of ineligibility for VA benefits

Financial Group and Insurance Group
O Above 125%
O Below 125%
O Medicaid SOC

Employment status verification type:

Account Number:

Name of Person Completing Intake:

O Checked RHIO for ER Hx
O Medicaid status verified

Eligibility Form

Section 3: Parent or Guardian Information

If this form is for a child under the age of 18, please complete the information about the child's parent or legal guardian.

Parent or Guardian's Name	Relationship	Home Phone Number	Patient at Grace?
			○ Yes ○ No
			○ Yes ○ No

Section 4: Emergency Contact Information

Emergency Contact Name	Relationship	Address	Phone

Section 5: Patient's Employment & Student Status

Which adults in the household are currently working?	**Who is your current employer? If you are not currently working, who was your most recent employer?**
○ Full-time ○ Part-time ○ None, last date of work was _____	
Are you currently a student? ○ Yes, part-time ○ Yes, full-time ○ No	**What school do you attend?**
Are you a migrant agricultural worker? (an individual whose principal employment is in agriculture on a seasonal basis and who establishes a temporary home for the purposes of such employment) ○ Yes ○ No	Are you a seasonal agricultural worker? (an individual whose principal employment is in agriculture on a seasonal basis and who does not establish a temporary home for purposes of employment.) ○ Yes ○ No

Section 6: OFFICE USE ONLY

GRACE MEDICAL HOME

For Office Use Only
- ❑ Entered into chart ❑ Scanned in eMDs
- ❑ Appointment Date _____
- ❑ Provider _____

For Physician Use Only
- ❑ Reviewed by: _____

Schedule with: ❑ Knights ❑NP ❑Doctor ❑female

Date:_____

Adult Health Summary Form

NAME:_____ **DOB: _____**

CURRENT PROBLEMS:

_____
_____
_____
_____

ALLERGIES TO MEDS/FOODS/OTHER AGENTS: ○ **NONE**

Medication	Reaction or Side Effects

CURRENT MEDICATIONS/ VITAMINS/ OTC: ○ **NONE**

Medication	Dose	Freq.	Medication	Dose	Freq.

PAST MEDICAL HISTORY:

Cardiovascular

- o Heart Rhythm Disturbance (Arrhythmia)
- o Congenital Heart Disease (specify type)

  _____
- o Congestive Heart Failure
- o Coronary Artery Disease
- o Deep Venous Thrombosis (DVT)
- o High Cholesterol (Hyperlipidemia)
- o High Blood Pressure (Hypertension)
- o Myocardial Infarction – Date _____
- o Other: _____

Pulmonary

- o Asthma
- o COPD
- o Sleep apnea
- o Other: _____

Gastrointestinal

- o Gall stones (Cholethiasis)
- o Liver Cirrhosis
- o Colon Polyps
- o Crohn's Disease
- o Reflux (GERD)
- o Hepatitis
- o Ulcerative Colitis
- o Other:

  _____

Kidney (Genitourinary)

- o Kidney (Renal) Stones
- o Other: _____

Musculoskeletal

Arthritis: ○Osteoarthritis ○Rheumatoid ○Unknown

- o Lupus (Systemic Lupus Erythematosis)
- o Other: _____

Endocrine

- o Diabetes: Circle - Type I Type II
- o Thyroid–
- o Hyperthyroidism
- o Hypothyroidism
- o Other: _____

Neurologic

- o Stroke (Cerebrovascular Accident)
- o Seizure disorder
- o Other: _____

Hematologic

- o Clotting (Coagulation) disorder
- o Sickle Cell Anemia
- o Other: _____

Allergy

- o Allergic rhinitis
- o Other: _____

Cancers

- o Type: _____

Other Medical Problems/Diseases:

- o _____
- o _____

For Women: Gynecologic History:

Pregnancies (gravid): _____ # Abortions:_____

Deliveries (parity): _____ # Miscarriages:_____

Sexually active: ○ Yes ○ No

Current Birth Control: Method: _____

Mammogram: ○ Yes ○ Never

Date of Last Mammogram: _____

Results: ○ Normal ○ Abnormal

Pap Smear: ○ Yes ○ Never

Date of Last Pap: _____

Results: ○ Normal ○ Abnormal

EMERGENCY ROOM HISTORY:

REASON	DATE

HOSPITALIZATIONS (Other than surgeries):

REASON	DATE

NOTE: If you have been to the ER or hospital in the last year, and you can find your discharge papers from that visit, **please bring them to your first appointment**. That will help your nurse and doctor understand better what happened and give you better care.

PREVIOUS MEDICAL PROVIDERS:

Primary Care Provider: _____

Specialists: _____

SURGICAL HISTORY:

OPERATION	DATE

FAMILY HISTORY:

Relative	Living?	Age (or age at death)	List serious illnesses
Father	(Y) (N)		
Mother	(Y) (N)		
Brothers	(Y) (N)		
	(Y) (N)		
Sisters	(Y) (N)		
	(Y) (N)		
Sons	(Y) (N)		
	(Y) (N)		
Daughters	(Y) (N)		
	(Y) (N)		
Paternal Grandfather	(Y) (N)		
Paternal Grandmother	(Y) (N)		
Maternal Grandfather	(Y) (N)		
Maternal Grandmother	(Y) (N)		

SOCIAL HISTORY:

Occupation: _____

Marital Status: O Single O Married O Divorced O Widowed

Number of Children: _____

Do you exercise regularly? (Y) (N) Frequency: O Rarely O Daily _____ days/week

TOBACCO USE:	**ALCOHOL USE:**
o Never Smoked o Current smoker o Every Day O Intermittent o Past smoker o Smokeless Tobacco	Do you drink alcohol? O Never O Past O Yes Number of drinks per week? _____ Is alcohol use a concern for you or others? O Yes O No

SUBSTANCE USE:

Do you use recreational/street drugs? O Yes O No

List/Type:

MENTAL HEALTH:	**COMMUNICABLE DISEASES:**
o Anxiety o Depression (Mood Disorder) o Bipolar (Mood Disorder) o Suicide Attempt o Schizophrenia o Other: _____	Sexually Transmitted Diseases? o Yes o No o List:_____ Reportable Diseases? o Hepatitis o Tuberculosis o Other? _____

PREVENTIVE CARE HISTORY

A colonoscopy is an exam in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. Have you ever had this exam?	Date of Last: _____ O Never	O Normal O Results Unknown O Abnormal O Refused
A tuberculosis skin test (PPD) is a small shot under your skin to see if you react to the tuberculosis protein. About 1-2 days after the test, someone checks the skin to see if you had a reaction. Have you had this skin test?	Date of Last: _____ O Never	O Normal O Results Unknown O Abnormal O Refused
Have you had either a flu shot or a flu vaccine (influenza)?	Date of Last: _____	O Never
Any other vaccines: o Gardisil (HPV) o Pneumococcal o Tetanus o Varicella Zoster (Shingles) Vaccine	Date of Last: _____ Date of Last: _____ Date of Last: _____ Date of Last: _____	O Never O Never O Never O Never

PREVENTIVE CARE HISTORY (Continued)

	Date	Results
A clinical breast exam is when a doctor, nurse, or other health professional feels the breasts for lumps. Have you had a clinical breast exam?	Date of Last: _____ O Never	O Normal O Results Unknown O Abnormal O Refused
A prostate exam for men is when a doctor, nurse, or other health professional feels for any abnormalities in the prostate. Have you ever had this exam?	Date of Last: _____ O Never	O Normal O Results Unknown O Abnormal O Refused
Blood cholesterol is a fatty substance found in the blood. Have you had your blood cholesterol checked?	Date of Last: _____ O Never	O Normal O Results Unknown O Abnormal O Refused
Have you had a test for high blood sugar or diabetes within the past three years?	Date of Last: _____ O Never	O Normal O Results Unknown O Abnormal O Refused
A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. Have you had this test using a home kit?	Date of Last: _____ O Never	O Normal O Results Unknown O Abnormal O Refused

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? O Yes O No

If no, have you ever been a regular patient at a health center or doctor's office? O Yes O No

When (what year) were you last seen as a patient there? _____ Last routine checkup? _____

Where would you typically go to get care for a sudden medical problem such as a sinus infection or a badly twisted ankle? Check ONLY ONE.

O Health Clinic O My regular doctor O Emergency Room
O Urgent care office (like Centra Care or Minute Clinic) O Would not get care
O Other (please describe)

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.

O I do not have a chronic illness
O Health Clinic O My regular doctor O Emergency Room
O Urgent care office (like Centra Care or Minute Clinic) O Would not get care
O Other (please describe)

Where would you typically go to get checkups, physicals, shots/immunizations, or other preventive care? Check ONLY ONE.

O Health Clinic O My regular doctor O Emergency Room
O Urgent care office (like Centra Care or Minute Clinic) O Would not get care
O Other (please describe)

ADDITIONAL MEDICAL QUESTIONS:

1. Are any medical conditions the result of an accident? ☐ Yes ☐ No

   If yes, then when and where? _____

2. Are any medical conditions a work related injury? ☐ Yes ☐ No

   If yes, please explain:_____

3. Are you retaining an attorney in relation to this condition/injury? ☐ Yes ☐ No

   If yes, please explain: _____

   _____

4. Are you currently under the care/supervision of any other physician for any aspect of your medical care?

   ☐ Yes ☐ No If yes, what are you being treated for? _____

5. Are you involved in a clinical trial? ☐ Yes ☐ No

   If yes, what is the name of the doctor and condition being treated for: _____

6. Have you ever been hospitalized or treated for chronic pain? ☐ Yes ☐ No

   If yes, please name the condition, dates, and facility where you were treated: _____

   _____

   6a. What medications have you taken for your chronic pain? _____

   _____

   6b. Is treatment for your chronic pain the primary reason for seeking services at Grace Medical Home?

   ☐ Yes ☐ No

7. Have you ever been hospitalized or treated for a psychiatric, mental health or emotional disorder? ☐ Yes ☐ No

   If yes, please name the date, diagnosis, and facility where you were treated: _____

   _____

   7a. What medications have you taken for your psychiatric, mental health, or emotional disorder? _____

   _____

   7b. Is treatment for a psychiatric, mental health, or emotional disorder the **main** reason for seeking services at Grace Medical Home? ☐ Yes ☐ No

8. Are you eligible for or receive public benefits such as Medicaid Share of Cost/Medically-Needy, or benefits through the Veteran's Administration? ☐ Yes ☐ No If yes, what type of benefits do you receive? _____

Signature: I certify by my signature that, to the best of my knowledge, the information entered in this Eligibility Form and Health Summary Form is true and complete. I further understand that failure to provide accurate information may result in discharge from Grace Medical Home.

_____	_____	_____
Patient Name	Patient Signature	Date

I, hereby, consent to the release of my demographic information only (name, address, social security number, and date of birth) to Florida Hospital and Orlando Health for the sole purpose of tracking whether cost savings have been achieved through primary care services offered at Grace Medical Home.

_____	_____	_____
Patient Name	Patient Signature	Date

GRACE MEDICAL HOME

51 Pennsylvania Street
Orlando, FL 32806

Tel: (407) 936-2785
Fax: (407) 936-2792

Consent for Release of Confidential Medical Records

Patient Name:_____ Date of Birth:_____

Purpose / Need for Information:

- Continuing Medical Care (Referred to Specialist)
- Insurance
- Moving
- Changing Physicians
- Legal Review/Action
- Personal Use
- Dissatisfied with care
- Over 18
- Other (Please Specify)

Specific Documentation Requested:

- Medical Records
- Mental Health Records
- Laboratory Reports
- Radiology Reports
- Other (Please Specify) _____

This information, including diagnosis and records of any evaluation, examination and/or treatment rendered to the above named during the period: _____

Information Requested From:_____

(Facility or Practice Name) _____

_____

_____ (Phone) _____ (Fax)

_____ _____

Signature of Patient / Legal Representative Date

_____ _____

Printed Name Relationship

This request is authorized to include any Federal and/or State protected information under Florida Statutes 394.459(9) Psychiatric Information. 397.053/396.112 Drug and/or Alcohol Abuse Information. 381.609 HIV and Aids Related conditions and/or 397.501(3) Records of a Minor Client.

I understand that this authorization will expire 90 days from the date of the signature or when acted upon, whichever event occurs first. I hereby release to the following addressee, its employees and appointed representatives from any and all liability that may arise from the release of information as I have directed.

This authorization for the release of the above indicated documents may be revoked at any time, upon notification of the patient or representative as signed above. Revocation has no effect on prior action taken under direction of the signed dated consent for release.

PATIENT CONSENT AND AUTHORIZATIONS

Your Signature Will Serve for All of the Following:

Consent: I hereby give consent for Grace Medical Home to provide necessary treatments discussed. I have received a copy of the Privacy Policy of Grace Medical Home and authorize use/disclosure of information to coordinate and/or manage my care or the care of my child(ren) and any related services, receive payment for services, and perform general healthcare operations.

Grace Medical Home may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations (TPO), such as appointment reminders, and any calls pertaining clinical care, including laboratory and radiology results among others.

Grace Medical Home may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, school immunization, and/or physical forms; all correspondence will be marked "Personal and Confidential".

Grace Medical Home may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO.

I permit the copy of this authorization to be use in place of the original.

Financial Responsibility: I understand that there is an annual enrollment fee to become a patient of Grace and that I am responsible for a small facility fee for office visits. I acknowledge that I am responsible for these charges.

Missed Appointment Policy: I understand that if I am not able to keep an appointment, I must call to reschedule. If I do not show up for 3 scheduled appointments without calling, I may be dismissed from being a patient with our practice.

_____ _____

Signature Date

_____

Print Name/Relationship

_____

Child's Name (Please Print)

51 Pennsylvania Street ● Orlando, FL 32806 ● (407)936-2785

Patient Authorization for Use or Disclosure of Protected Health Information

I, _____, hereby authorize use or disclosure of protected health information about me as described below:

1. Grace Medical Home is authorized to use or disclose information about me:
2. The following person (or class of persons) may receive disclosure of protected health information about me:
   Name and Address: _____
   _____
   _____

This Protected Health Information would be disclosed as described in our privacy policies for the maintenance and delivery of care.

Unless you sign here, no information about alcohol/substance abuse, HIV/AIDS, or Mental Health will be disclosed:

YES, disclose this information: _____

NO, DO NOT disclose this information: _____

I understand that I do not need to consent to the release of this information. I will not be denied treatment if I do not authorize the requested use and disclosure of this protected health information. By signing this release, I give my consent willingly for the specified above.

This Authorization shall be in force and effect until _____ at which time this Authorization to use or disclose this Protected Health Information shall expire.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to Privacy Office at Grace Medical Home, 51 Pennsylvania Street, Orlando, FL 32806. I understand that a revocation is not effective to the extent that Grace Medical Home has relied on the use or disclosure of the Protected Health Information.

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to:

- Inspect or copy the Protected Health Information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this Authorization

I have reviewed the information above, and any questions I may have had about this form have been answered to my satisfaction. I have been offered and/or given a copy of this form.

_____ _____
Signature (patient over 18 years of age) Date

_____ _____
Signature of parent/guardian Relationship to Patient

_____ _____
Witness to signature Date

Copy of this form was offered to client. Copy was _____ accepted _____ refused

ORLANDO HEALTH
1414 Kuhl Avenue • Orlando, Florida 32806-2093

LINE UP PATIENT I.D. LABEL HERE

AUTHORIZATION TO OBTAIN, RELEASE OR REVIEW PROTECTED HEALTH INFORMATION

Patient Name:_____ Social Security #:_____

Address:_____

Date of Birth: ____/____/____ Date of Service:_____ Phone #:_____

Identification Shown:_____ Mail ❑ Pick Up ❑

I hereby authorize Orlando Health to use and **disclose to:** ❑ **or obtain from:** ☐ **or allow review:** ❑

_____ _____
Name of Facility or Person Phone

_____
Street Address City State Zip Code

SEND RECORDS TO: (Name of Facility or Person) **GRACE MEDICAL HOME**

51 PENNSYLVANIA STREET **ORLANDO** **FL** **32806**
Street Address City State Zip Code

the following information contained in my medical record regarding my hospitalization, care and treatment (please initial):

____ Complete Record
____ Abstract of Record
____ Therapy Records
____ Progress Note(s)
____ All Diagnostic Test Results
____ Consultation
____ Radiology Only
____ Operative Report
____ Pathology Report(s)
____ Lab Only
____ Other (please specify) _____

The purpose for the release of information at the request of the individual is:
❑ Insurance ❑ Legal Action ☑ Continued Treatment ❑ Personal Use ❑ Patient Communication (Behavioral Health)
❑ Other (Please Specify) _____

This authorization will expire on the following date, event or condition: **1 Year**
I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initialed below or otherwise required by law.

May **NOT** include information related to (please initial):

____ HIV/AIDS ____ Mental Health ____ Drug and/or Alcohol Abuse ____ Genetic Counseling/Testing Information

If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that Orlando Health may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization. I understand that I will receive a signed copy of this form.

_____ _____
Patient/Legal Representative or Parent/Legal Guardian Signature Date

Translator or Interpreter's Name: _____

Official Use Only: _____ Date:_____

☐ Name of Person Releasing Information ☐ Name of Person Assisting with Review Number of pages copied _____

☐ **I wish to revoke this authorization.** Signature: _____ Date: _____

Form **4506-T**

(Rev. January 2011)

Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

► **Request may be rejected if the form is incomplete or illegible.**

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Transcript" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (See instructions)

4 Previous address shown on the last return filed if different from line 3 (See instructions)

5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax information.

Grace Medical Home, 51 Pennsylvania St., Orlando, FL 32806

Caution. *If the transcript is being mailed to a third party, ensure that you have filled in line 6 and line 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy.*

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ►

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120A, Form 1120H, Form 1120L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . . ☐

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 30 calendar days. . ☐

c **Record of Account,** which is a combination of line item information and later adjustments to the account. Available for current year and 3 prior tax years. Most requests will be processed within 30 calendar days . . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2007, filed in 2008, will not be available from the IRS until 2009. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 45 days . . . ☐

Caution. *If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.*

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, **either** husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note.** *For transcripts being sent to a third party, this form must be received within 120 days of signature date.*

Telephone number of taxpayer on line 1a or 2a

Sign Here

► **Signature** (see instructions) | Date

► **Title** (if line 1a above is a corporation, partnership, estate, or trust)

► **Spouse's signature** | Date