State of Florida
Department of Health

Notice of Privacy Practices Acknowledgment Form

Name : _____ Client ID# _____

Facility/Site/Program : *537 NW Lake Whitney Place Suite #101, PSL, FL 34986*

I have received a copy of the DOH Notice of Privacy Practices Form DH 150-741, 09/13.

Signature: _____ **Date :** _____
Individual or Representative with legal authority to make health care decisions

If signed by a Representative:

Print Name: _____ **Role:** _____
(Parent, guardian, etc.)

Witness: _____ Date: _____

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If the individual has a representative with legal authority to make health care decisions on the individual's behalf, the notice must be given to and acknowledgment obtained from the representative. ***If the individual or representative did not sign above, staff must document when and how the notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.***

Notice of Privacy Practices given to the individual on _____
Date

☐ Face to face meeting
☐ Mailing
☐ Email
☐ Other _____

Reason Individual or Representative did not sign this form:
☐ Individual or Representative chose not to sign
☐ Individual or Representative did not respond after more than **one** attempt
☐ Email receipt verification
☐ Other _____

Good Faith Efforts: The following good faith efforts were made to obtain the individual's or Representative signature. Please document with detail (e.g., date(s), time (s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature. More than **one** attempt must have been made.

☐ Face to face presentation(s) _____
☐ Telephone contact(s) _____
☐ Mailing(s) _____
☐ Email _____
☐ Other _____

Staff Signature: _____ Title: _____
Print Name: _____
Date: _____

This form must be retained for a period of at least six years in the appropriate record.

INITIATION OF SERVICES

PART I **CLIENT-PROVIDER RELATIONSHIP CONSENT**

Client Name: _____

Name of Agency: **Florida Department of Health in St Lucie County**

Agency Address: **537 NW Lake Whitney Place Suite #101, PSL, FL 34986**

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical visits including obtaining medical history, assessment, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue this relationship at any time.

PART II **DISCLOSURE OF INFORMATION CONSENT** (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my health information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations.

PART III **MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST** (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my health information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above-named agency and authorize it to submit a claim to Medicare for payment.

PART IV **ASSIGNMENT OF BENEFITS** (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above-named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V **COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER**

(This notice is provided pursuant to Section 119.071(5)(a), Florida Statutes.)

For health care programs, the Florida Department of Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071(5)(a)2.a. and 119.071(5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Florida Department of Health is imperative for the performance of duties and responsibilities as prescribed by law.

PART VI **MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS**

_____ _____ _____

Client/Representative Signature **Self or Representative's Relationship to Client** **Date**

_____ _____

Witness (optional) Date

PART VII **WITHDRAWAL OF CONSENT**

I, _____ WITHDRAW THIS CONSENT, effective _____

Client/Representative Signature Date

_____ _____

Witness (optional) Date

Client Name: _____

ID#: _____

Original to file; Copy to client

DOB: _____

CONSENT FOR SERVICES AND COMMUNICATIONS

Patient Name: _____ **DOB:** _____

I. Consent for Services

I, _____, being the parent/guardian of a minor under the age of 18 years, hereby give my signed consent to the Florida Department of Health to provide dental services, including any procedures or treatments determined necessary and in the best interest of the above child, according to dental accepted procedures and treatments. I understand my consent is necessary before the Florida Department of Health can provide services to anyone less than 18 years of age. I further understand that this consent will remain in effect until retracted by me in writing to the Florida Department of Health.

	Name	Relationship	Contact Number
1.			
2.			
3.			

If I'm unable to bring my child for services, I give my consent for the person(s) listed above to represent me for any procedures or treatments necessary and in the best interest of the above child.

II. Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications:

We want to stay connected with our patients. Our practice may contact you vial email, calls to your cellular phone (including prerecorded voice messages) and/or text messaging to confirm your appointment, to obtain feedback on your experience with our healthcare team, and to provide general health/treatment reminders and information. If at any time you provide an email address and cellular phone number below, you understand that you may get these communications from our practice. you may opt out of these communications at any time. The practice does not charge for this service, but standard text messaging rates or cellular phone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

☐ **I authorize** to receive txt messages and or phone calls for appointment reminders, feedback, and general health reminders/information. The Phone number is _____.

☐ **I authorize** to receive emails messages for appointment reminders and general health reminders, feedback, and information. the email address is _____.

III. Withdrawal of Consent

I decline _____ (Patient/Parent/Guardian Initials) to receive communication via text.

I decline _____ (Patient/Parent/Guardian Initials) to receive communication via cellular phone.

I decline _____ (Patient/Parent/Guardian Initials) to receive communication via email

_____ _____

Patient/Parent/Guardian's Signature **Date**

_____ _____

Witness Signature **Date**

Dental Health History

Name _____
ID No. _____
Birth Date _____

In the following questions, circle **Yes** or **No**, whichever applies. Your answers will be considered confidential.

1. Do you **(PATIENT)** have or have you **(PATIENT)** had any of the following:

Rheumatic Fever or Heart Murmur	Yes	No	Neurological Problems	Yes	No
Heart Trouble or Shortness of Breath	Yes	No	Tuberculosis (TB) or Persistent Cough	Yes	No
High or Low Blood Pressure	Yes	No	Diabetes or Excessive Thirst	Yes	No
Fainting or Dizzy Spells	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Kidney Problems or Excessive Urination	Yes	No
Anemia or Blood Problems	Yes	No	Liver Problems or Hepatitis	Yes	No
Sickle Cell Anemia	Yes	No	Venereal Disease	Yes	No
Excessive Bleeding or Bruise Easily	Yes	No	AIDS/ARC/HIV Positive	Yes	No
Blood Transfusions	Yes	No	Cancer	Yes	No
Allergies or Skin Rash	Yes	No	Pregnancy	Yes	No
Asthma	Yes	No	Trimester 1 2 3		
Thyroid Problems	Yes	No	Painful or Swollen Joints	Yes	No
Emotional Problems	Yes	No	Other _____	Yes	No

2. Are you **(PATIENT)** currently under the care of a physician (doctor)? Yes No
   If yes, list name of doctor. _____

3. Have you **(PATIENT)** been hospitalized in the last 2 years? Yes No
   If yes, why? _____

4. Are you **(PATIENT)** currently taking any medications, pills or drugs? Yes No
   If yes, list. _____

5. Are you **(PATIENT)** allergic to or have you ever experienced any ill effect from a local anesthetic (novocain), penicillin, or any drugs/pills? i.e., rash, itching or fainting. Yes No
   If yes, describe. _____

6. Have you **(PATIENT)** ever experienced any unfavorable reaction from previous dental treatment? Yes No
   If yes, describe. _____

7. Are you **(PATIENT)** currently having any dental pain or problem? Yes No
   If yes, describe. _____

I certify that I have read and understand the above questions and have answered the questions to the best of my knowledge. I have asked for an explanation of any terms (words) that I did not know (if any), and my questions have been answered to my satisfaction. I will not hold my dentist, or any of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

I also understand that before treatment is provided, I have the right to have the benefits, alternatives, and significant risk factors associated with this treatment explained to my satisfaction.

Signature of Patient _____ Date _____
(If patient is a child, parent or legal guardian must sign) Relationship _____

Comments by Dentist: _____

_____

_____

Signature of Dentist _____ Date _____

DH 3117, 10/96 (Part 5) (Replaces HRS-H Form 3117, part 5, which may be used)
(Stock Number: 5744-005-3117-7)