Medical Record #
(For office use only)

Client Registration

Please note: 26Health uses one inclusive health intake form for both our medical and behavioral health clients to maintain continuity of your care. To provide our clients with optimal health care, we must obtain a thorough medical history for all clients. We recognize that the information requested may be sensitive and want to assure you that your responses are confidential and used solely to provide care designed to meet your individualized health needs. Some routine questions include social, sexual, and coping behaviors for all patients, as they are vital to providing quality care regardless of sexual orientation or gender identity.

LEGAL NAME	Last	First	Middle initial	Preferred name
LEGAL SEX (Please check one)* ☐ Female ☐ Male **While 26Health recognizes many genders/sexes, many insurance companies and legal entities, unfortunately, do not. Please be aware that the name and sex you have listed on your insurance must be used on documents about insurance, billing, and correspondence. If your preferred name and pronouns are different from these, please let us know.*				Preferred pronouns
Date of Birth	(MM/DD/YYYY)	Social Security #	State ID # or Driver License #	

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Home telephone number ( ) Ok to leave a voicemail? ☐ Yes ☐ No	Cell telephone number ( ) Ok to leave a voicemail? ☐ Yes ☐ No	Work telephone number ( ) Ok to leave a voicemail? ☐ Yes ☐ No	Best number to use ☐ Home ☐ Cell ☐ Work

Address	City	State	ZIP
Billing Address (If different from above)	City	State	ZIP
Email address			
Occupation	Employer/School Name	Are you covered under school or employer's insurance? ☐ Yes ☐ No	
Emergency contact's name	Telephone number	Relationship to you	
If you are under 18, the Department of Public Health requires that you provide parent/guardian contact information. Parent/Guardian name	Telephone number	Relationship to you	
26Health will send certain correspondence, such as bills, to your mailing address. How would you prefer to receive other types of written correspondence? (Check one) ☐ Email ☐ Letter ☐ Other			
Primary care physician	Telephone number	Address	
Health insurance carrier	Member ID #	Group #	

This information is for demographic purposes only and will not affect your care.

1) What is your annual income? _____ ☐ No Income 1a) How many people including you does your income support? _____	**2) Employment status** ☐ Employed full-time ☐ Employed part-time ☐ Student part-time ☐ Student full-time ☐ Retired ☐ Unemployed ☐ Other _____	**3) Racial group(s) (Check all that apply)** ☐ African American / Black ☐ Caucasian / White ☐ Native American / Alaskan Native / Inuit ☐ Asian ☐ Pacific Islander ☐ Other _____	**4) Ethnicity** ☐ Hispanic/Latino/Latina/Latinx ☐ Not Hispanic/Latino/Latina
5) Country of Birth ☐ The U.S.A. ☐ Other _____	**6) Veteran status** ☐ Veteran ☐ Not a Veteran	**7) Preferred language (Choose one)** ☐ English ☐ Spanish ☐ French ☐ Portuguese ☐ Creole ☐ Other _____	**8) Referral source** ☐ Self ☐ Friend or Family member ☐ Health Provider ☐ Emergency room ☐ Ad/Internet/Outreach event ☐ Work/School ☐ Agency _____ *(Please add source)* ☐ Other _____
9) Living situation? ☐ By yourself ☐ With spouse/partner ☐ With roommate ☐ Parents/family member ☐ Community living ☐ Homeless ☐ Other _____	**10) Marital status** ☐ Married ☐ Partnered ☐ Single ☐ Divorced ☐ Domestic Partnership/Civil Union ☐ Polyamory (Involved with multiple partners) ☐ Other _____	**11) What was your sex at birth?** ☐ Female ☐ Male ☐ Intersex	**12) Do you identify as…** ☐ Female ☐ Male ☐ Transgender ○ Female to Male ○ Male to Female ☐ Other _____
13) Do you identify as… ☐ Lesbian, gay or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Transgender ☐ Pansexual ☐ Bi-Gender ☐ Non-Binary ☐ Heterosexual ☐ Questioning ☐ Intersex ☐ Asexual ☐ Queer ☐ Other_____	**14) Are you currently sexually active?** ☐ Yes ☐ No **If no, have you ever been sexually active?** ☐ Yes ☐ No	**15) Sexual partners in the last <u>6 months</u>? *(all that apply)*** ☐ Female ☐ Male ☐ Transgender ○ Female to Male ○ Male to Female ☐ MSM ☐ Other _____ **In the past 6 months, how many sexual partners have you had?** _____	**16) Past sexual partners? *(all that apply)*** ☐ Female ☐ Male ☐ Transgender ○ Female to Male ○ Male to Female ☐ MSM ☐ Other _____
17) What kind of sexual contact do you have or have you had? ☐ Genital ☐ Anal ☐ Oral ☐ Other _____	**18) Do you or your partner(s) use any protection against STIs?** ☐ Yes ☐ No **If yes, what kind of protection?** _____ **How often do you use this protection?** _____	**19) Have you ever been tested for STIs?** ☐ Yes ☐ No Chlamydia ☐ Yes ☐ No Gonorrhea ☐ Yes ☐ No Syphilis ☐ Yes ☐ No **If yes, when were you tested?** _____ **What was the diagnosis?** _____ **How was it treated?** _____	**20) Has your current partner or any former partner(s) ever been diagnosed or treated for an STI?** ☐ Yes ☐ No **Where you tested for the same STI?** ☐ Yes ☐ No **If yes, when were you tested?** _____ **What was the diagnosis?** _____ **How was it treated?** _____

21) Would you like to be tested for STIs today? ☐ Yes ☐ No	**22) Do you need any information about safer sex techniques?** ☐ Yes ☐ No **If yes, with:** ☐ Female ☐ Male ☐ Transgender ○ Female to Male ○ Male to Female ☐ MSM ☐ Other _____ **Would you like to receive condoms today?** ☐ Yes ☐ No	**23) Are you HIV positive?** ☐ Yes ☐ No **If yes, when were you diagnosed?** _____ **How were you treated?** _____ _____ _____ _____	**24) Would you like to be tested for HIV today?** ☐ Yes ☐ No _____ **When were you tested?** _____ **What was the diagnosis?** _____ **How was it treated?**
25) Have you ever been tested for Hep C? ☐ Yes ☐ No **If yes, when were you tested?** _____ **What was the diagnosis?** _____ **How was it treated?** _____	**26) Have you had Hep A or B vaccination?** ☐ Yes ☐ No **If yes, when?** _____ **If no, would you like to be vaccinated today?** _____	**27) Have you ever been diagnosed with it?** **Genital Herpes** ☐ Yes ☐ No **Human Papilloma Virus (HPV)** ☐ Yes ☐ No	**28) Needle Usage:** ☐ Yes ☐ No **If yes, how often?** _____ **Have you shared needles?** ☐ Yes ☐ No **Do you share needles with your partner?** ☐ Yes ☐ No **If yes, how often?** _____
29) Do you want to start a family? ☐ Yes ☐ No ☐ Would like more information	**30) Do you have any questions concerning starting a family?** ☐ Yes ☐ No ☐ Adoption	**31) Do you have any concerns related to your gender identity/expression or your sex assignment at birth?** ☐ Yes ☐ No Please explain _____ _____ _____ _____	**32) Do you currently use or have you used hormones for any reason? (e.g. testosterone, estrogen, etc.)** ☐ Yes ☐ No ☐ Other _____
33) Do you need any information about hormone therapy? ☐ Yes ☐ No	**34) Do you drink alcohol?** ☐ What type? _____ ☐ How much? _____ ☐ How frequent? _____	**35) Do you smoke or use tobacco/nicotine?** ☐ What type? _____ ☐ How much? _____ ☐ How frequent? _____	**36) Do you use recreational drugs?** ☐ What type? _____ ☐ How much? _____ ☐ How frequent? _____

Date of the last physical? _____

Any vision or hearing loss? (Describe) _____

Any life-threatening conditions? (Describe) _____

Have you been recently hospitalized? ☐ Yes ☐ No If so, describe _____

List of medications, both prescribed and non-prescribed (Please include vitamins and supplements).

Name	Dose	Frequency	Reason
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Do you take other medications (vitamins or supplements) besides the ones above listed?

☐ Yes
☐ No
☐ Other _____

Have you ever been diagnosed with the following?

Diabetes	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Nervous disorder	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No	Depression	☐ Yes	☐ No
Seizures or epilepsy	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Obesity	☐ Yes	☐ No
Lung disorder	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Kidney disorder	☐ Yes	☐ No	Other ☐ Yes ☐ No (Please list)		
Blood disorder	☐ Yes	☐ No			

What surgical procedures have you had in the past? Please list ALL procedures, dates, and reason for the procedure.

Procedure	Date	Reason for procedure

What organs have you had removed? Please check all that apply.

☐ Adenoids	☐ Cervix	☐ Lung (Right/Left)	☐ Spleen	☐ Tonsils
☐ Appendix	☐ Colon	☐ Ovaries (Right/Left)	☐ Stomach	☐ Uterus
☐ Bladder	☐ Gallbladder	☐ Penis	☐ Testes (Right/Left/Both)	☐ Vagina
☐ Breasts	☐ Kidney (Right/Left/Both)	☐ Prostate	☐ Thyroid	☐ Other _____

Family medical history: Anyone in the family with a history of any of the following? Please indicate whom.

Condition *include their gender* →	Parent 1 _____	Parent 2 _____	Grandparents	Siblings	No family medical history? Please describe why
Diabetes	☐	☐	☐	☐	
High blood pressure	☐	☐	☐	☐	
Heart disease	☐	☐	☐	☐	
Arthritis	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	
Thyroid condition	☐	☐	☐	☐	
Lung condition	☐	☐	☐	☐	
Kidney disease	☐	☐	☐	☐	
Epilepsy	☐	☐	☐	☐	
Mental illness	☐	☐	☐	☐	
Cancer (Describe) _____	☐	☐	☐	☐	
Other (Please list) _____					

Please describe any drugs, food, and environmental allergies or sensitivities.

Allergen	Reaction type	Reaction severity

Please include any other specific medical information.

_____

_____

_____

_____

_____

Please list your primary pharmacy.

Name of Pharmacy _____

Address _____

City_____State_____Zip Code _____

Phone Number _____

MEDICAL TREATMENT AUTHORIZATION AND CONSENT FORM

This treatment consent form covers all procedures that are not of a nature to require special consent, and it protects the procedures by the professional staff of 26Health Services, Inc. This form documents that the patient/client has consented to treatment at 26Health Services, Inc. including but not limited to medication management, psychotherapy, and counseling. This allows the professional staff of 26Health. to provide services to you. If you have any questions concerning this or any other matters, it is your responsibility to ask your provider. By signing this form, you acknowledge that you understand your consent to treatment as explained in this form.

I do hereby voluntarily consent to care and treatment by 26Health Services, Inc.

Print Name _____

Signature _____

Date _____

• If you wish to include the name(s) of an individual(s) (e.g., spouse, child, relative, other) to whom we can discuss your Private Health Information (PHI), please write their names here: _____

_____

• If I am consenting to treatment for another person, I certify that I am legally responsible for that person and am entitled to consent to treatment for them.

Patient/Client Name _____

Print Name _____

Signature _____

Date _____

Address _____

City_____State_____Zip Code _____

Phone Number _____

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with an appreciation of his or her dignity, and with the protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, before treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

By signing below, I acknowledge that I have fully read and understood the above policies and agree to abide by them.

_____

Patient's Name

_____

Patients' Signature

_____

Date

26Health Acct. #

Authorization to Obtain or Release Protected Health Information

PATIENT INFORMATION (Please print)

First Name	Middle Initial	Last Name	
Name at Time of Treatment (If different than above)			
Date of Birth (MM/DD/YYYY)	Telephone number	E-mail (Optional)	
Address	City	State	Zip

☐ **Obtain** or ☐ **Release** information checked below from my records or those of the individual for whom I am the legal guardian.

What records do you want? (Check appropriate boxes below)

Date(s) of Service:_____/____/____through____/____/____

Information to be disclosed	
☐ History, physical, and Immunization records	☐ Discharge summary
☐ Clinic notes including nurses notes and medication list	☐ Operative report
☐ Progress notes including provider orders	☐ Urgent care report
☐ Diagnostic reports (Lab, X-ray, EKG, EEG, EMG, etc.)	☐ Emergency department report
☐ Pathology reports	☐ Medical and/or Behavioral health consults
☐ Other (please specify)	

Unless revoked, this authorization expires in 180 days or on this date _____

I understand and agree that the information below will be disclosed if I place my initials in the applicable space next to the type of information.

_____HIV/AIDS testing/treatment

_____Genetic testing

_____Mental Health specific visits and Psychotherapy notes

_____Drug/Alcohol specific visits

Where do you want the information sent? (Fill in boxes below)

Recipient ☐ or Sender ☐ (Please check one)	Recipient ☐ or Sender ☐ (Please check one)
26Health	Name (Provider/Facility)
801 N. Magnolia Ave. Suite 402	Address
Orlando, FL 32803	City, State, Zip
Tel: 321-800-2922 Ext. 1500 Medical or 1600 Behavioral Health	Telephone number
Fax: 888-972-6451	Fax:

Please print your name and sign below

_____ Name of Patient or Representative (please print)

_____ Relationship (please print)

_____ Signature of Patient or Personal Representative

_____ Date/Time

For Staff Use Only	
Date Processed	Processed by

MEDICAL & BEHAVIORAL HEALTH
APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your health care to 26Health Service. Please see our Appointment Cancellation/No Show Policy below:

- Effective April 15, 2019, any established patient/client who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a No Show and charged a $25.00 fee.
- Any established patient/client who fails to show or cancels/reschedules an appointment with no 24-hour notice a second time within three (3) months will be charged a $25.00 fee.
- If a third No Show or cancellation/reschedule should occur within the same period, the patient/client will not be able to reschedule for three (3) months or until the balance is paid in full.
- We understand that delays can happen however, we must try to keep the other patients/clients and providers on time. If a patient/client is 15 minutes past their scheduled time, the provider will be consulted to see if the patient/client can be seen. If we need to reschedule the appointment the patient/client will be charged a $25.00 fee.
- The fee is charged to the patient/client, not the insurance company, and is due at the time of the next office visit.

As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect. Please make sure we have your current contact information on file.

_____

Patient/Client Name

_____

Patient/Client Signature

_____

Date

Rev. Nov. 1, 2019

SLIDING FEE INFORMATION

26Health ensures that no one will be denied access to health services due to their inability to pay.

Our sliding fee program allows us to reduce or "slide" the fees for the care of you or your family. You can apply for the program if you need assistance to help you pay for your care.

Eligibility is based on family income and family size and granted for three (3) months at a time. The minimum amount is due at the time of your visit, as well as payment for any other unpaid balances. Every three (3) months 26Health will work with you the reapply for eligibility.

TO APPLY FOR THE SLIDING FEE:

If a patient is employed they must show which bracket of the sliding scale they qualify for with the following documents:

1. Required copy of recent paystubs.
    - Four (4) most recent if they are paid weekly.
    - Two (2) if they are paid biweekly.
    - One (1) if they are paid monthly.
2. Required copy of IRS form 1040 if they have dependents.

If a patient is unemployed and is supported by another individual. The supporting individual must show which bracket of the sliding scale they qualify for with the following documents:

1. Required copy of recent paystubs.
    - Four (4) most recent if they are paid weekly.
    - Two (2) if they are paid biweekly.
    - One (1) if they are paid monthly.
2. Required copy of IRS form 1040 if they have dependents.

If a patient is collecting Social Security Income/Disability it is still necessary for the patient to show which bracket of the sliding scale they qualify for with the following documents:

1. Required copy of the Social Security Income, (SSI) Awarded Letter.
    - Every year people who collect SSI receive a letter that shows their monthly payouts for the year.
2. Required copy of the IRS form 1040 if they make over $12,000 a year.
    - People who make under $12,000 a year in Social Security are not required to file taxes.

Unemployed and receiving unemployment income
Required copy of the last four (4) paystubs

1. Required copy of IRS form 1040 if they have dependents.

SLIDING FEE SCALE - Based on 2019 Federal Poverty Guidelines

Federal Poverty Level	100% FPL	150% FPL	200% FPL	250% FPL	300% FPL	>400% FPL
Slide Level	A	B	C	D	E	F
Medical and Behavioral Health Sliding Fee						
Patient Pays	25%	30%	40%	50%	75%	100% of charges
Discount	75%	70%	60%	50%	25%	