(Please Print)

Today's Date:

PATIENT INFORMATION

Patient's Last Name: | First: | Middle: | ☐ Mr. ☐ Mrs. ☐ Ms.

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

Race: ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black/African American ☐ White/Caucasian ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Is this your legal name? ☐ Yes ☐ No | If not, what is your legal name? | Birth date: | Age: | Gender: ☐ M ☐ F Identify As: ☐ M ☐ F

Street address: | Social Security Number: | Home Phone Number:

City: | State: | Zip Code: | Cell Phone Number:

Employed: ☐ Yes ☐ No ☐ Full Time ☐ Part Time ☐ Other

Occupation: | Employer: | Employer Phone Number:

Address:

Chose clinic because/referred to clinic by (Please check one box):

☐ Dr. ☐ Family ☐ Friend ☐ Other

IN CASE OF EMERGENCY

Name:

Address: | Relationship to Patient: | Home Phone Number: | Work Phone Number:

The above information is true to the best of my knowledge.

Patient/Guardian signature *Date*

St. Lucie County Health Access Network Inc. /dba HANDS
3855 South US 1, Suite B • Fort Pierce, FL 34982
Tel.: (772) 462-5646 • (772) 344-2541 • Fax: (772) 595-1309
Email: info@handsofslc.org • Web: www.handsofslc.org

I, _____

understand that as a patient of the HANDS clinic it is my responsibility to keep my scheduled appointments. If I am unable to keep my appointment I will call to cancel and reschedule as soon as possible.

I also understand that if I miss 3 appointments without calling to cancel I may be deactivated from the HANDS clinic.

_____ _____

Signature Date

_____

Patient Navigator

St. Lucie County Health Access Network Inc. /dba HANDS
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This is a form to obtain your consent to receive appointment reminders and messages. **Signing this form is voluntary.** Whether or not you sign, the treatment you get from us will be the same.

Cost. Standard text message and minute usage rates from your mobile or Internet service provider may apply.

Risks. Sending and receiving text, email and voice messages from us may impact the privacy and security of your Personal Health Information ("PHI"). Examples of PHI are: name, medical condition, or insurance coverage.

- Text, email and voice messages are not encrypted. Encryption makes sure your information stays safe. Information in text, email and voice messages may not be secure.
- If you share your phone, email, or your mobile phone is lost or stolen, someone other than us may be able to access your PHI. Messages can be read, used or shared by people other than us.

I, the Patient, understand and accept each of the following:

- **I authorize HANDS of St. Lucie County to send me text, email and voice messages.** This includes (but is not limited to) treatment- or care-related reminders.
- Text, email, and voice messages from HANDS of St. Lucie County may contain PHI. I will be responsible for information I share with HANDS of St. Lucie County.
- This consent will be in effect as long as I receive treatment from HANDS of St. Lucie County. I can ask HANDS of St. Lucie County for a more secure form of communication, like telephone.
- I will let HANDS of St. Lucie County know if my phone number changes. I can call (772) 462-5646 or send an email to info@handsofslc.org .
- I can cancel by signing a cancellation form.
- I have a right to receive a copy of this consent form for my records.

I have read the above information and, by signing below, I confirm:

_____ **Yes! I want to receive appointment reminders.**

_____ **No. I do not want to receive appointment reminders.**

_____ _____

Signature of Patient or Patient's Representative | Date

_____ _____

Printed Name of Patient or Patient's Representative | Representative's Relationship to Patient

HANDS
of St. Lucie County

RELEASE AND CONSENT FORM

I / We, the undersigned, hereby authorize you to release, without liability, information regarding my/our employment, income and/or assets to **the H.A.N.D.S. of St. Lucie County** (Health Access Network Delivery Systems), for the purpose of verifying information provided as part of the application for financial assistance.

I / We agree that a photocopy of this form may be used for the purpose stated above. The original of this authorization is on file with **the H.A.N.D.S. of St. Lucie County**.

I / We certify that the information provided in the Application and Income/Expense Certification is correct and may be verified as part of the review process. **I understand that the material representation of facts may result in prosecution to the fullest extent of the law.**

Information may be requested from, but not limited to, the following groups or individuals: past and present employers, public assistance agencies, Veterans Administration, unemployment agencies, retirement systems, support and alimony providers, Social Security Administration, utility providers, insurance companies, financial institutions, physicians, hospitals, medical care providers and government.

Applicant Signature	Print Name	Date	SS#
Co-Applicant Signature	Print Name	Date	SS#
Signature Household Member 18 years or older	Print Name	Date	SS#
Signature Household Member 18 years or older	Print Name	Date	SS#
Signature Household Member 18 years or older	Print Name	Date	SS#

General Medical Records Release and Authorization
For Use or Disclosure of Protected Health Information

Patient Name: _____

Address: _____

_____

Phone: _____ Email: _____

SSN: _____ Date of Birth: _____/_____/_____

I authorize the custodian of records of: _____
or other person/entity (specifically describe) to disclose/release the following information:

_____ All Records
_____ Laboratory / Pathology Records
_____ X-ray / Radiology Records
_____ Abstract / Summary
_____ Pharmacy / Prescription
_____ Billing Records
_____ other (describe specifically)
_____
_____

These records are for services provided.

Please send the records listed above to:

HANDS of St. Lucie County
3855 South US 1, Suite B
Fort Pierce, FL 34982
Phone: 772-462-5646 / **FAX: 772-595-1309**

The information may be used / disclosed for each of the following purposes:
_____ At my request (only the patient can check this box)
_____ For my health care
_____ For payment / Insurance

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of Patient (or patient's personal representative) Date

_____ _____
Printed Name of Patient or Representative Representative's Authority to Sign for Patient (i.e. Guardian, Power of Attorney, Executor)

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Privacy Liaison, HAND of St. Lucie County 3855 South US 1, Suite B, Fort Pierce, FL 34982

If these records contain any information from previous providers or information about HIV / AIDS status, cancer diagnosis, drug /alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

HANDS of St. Lucie County

3855 South US 1, Suite B
Fort Pierce, FL 34982

Patient's Authorization to Release Medical Information

I understand that my family members, friends, and co-workers may ask questions about my medical condition over the telephone or in person. I also understand it is a breach of physician-patient confidentiality for my doctors to discuss my medical information any way with anyone without my expressed written consent. By signing this form I am designating the parties below with whom I wish HANDS of St. Lucie County to be able to discuss my medical condition.

In accordance with the above, I _____, hereby authorize HANDS of St. Lucie County to discuss with and release my medical information to the following individuals:

_____ _____
Name Relationship

_____ _____
Name Relationship

NOTIFY IN CASE OF EMERGENCY:

_____ _____
Name Relationship

The below individuals are authorized to pick up any written prescriptions, medication samples or x-ray films on my behalf:

_____ _____
Name Relationship

_____ _____
Name Relationship

Furthermore, I understand that if there is any information in my medical record I do not want discussed with or released to the above. I must designate it here by stating what information is to be excluded.

_____ _____

_____ _____

Patient Signature: _____

Patient Printed Name: _____

Date: _____

Witness: _____

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ADDITIONAL INFORMATION

1) As noted on your HANDS referral form you may be referred to outside providers. Your referral and information will be faxed over to the volunteer provider. Please do not contact the provider yourself unless otherwise instructed to do so.

When the provider has agreed to provide services to you, either HANDS or the referring provider's office will contact you regarding an appointment date and time.

We appreciate the free services provided to HANDS patients and do our best to not burden offices with unnecessary calls. **If you insist on contacting the referring provider's office without permission you may be placed on probation or discharged from the clinic.**

2) As noted on your HANDS Clinic referral form you may be referred to outside providers at no cost to you, but you may be charged for further services incurred during the testing. You should not receive a bill from the hospital for outpatient testing, but you may receive a bill from the radiologist, pathologist, anesthesiologist, etc. These individuals do not have a sovereign immunity contract with HANDS Clinic and can bill you for services.

If you receive a bill please bring the original to the clinic. We will send a "Request for Charity Services Letter" to the provider asking that they write off or reduce the bill. It is at the individual provider's discretion to make changes to your bills. **You will be responsible for these bills if the provider denies the charity request.**

_____

Printed Name

_____ _____

Signature Date

Patient portal

St. Lucie Medical Center & Lawnwood Regional Medical Center

Your hospital's Patient Portal enables you to instantly and safely access the personal health information your care team entered into your record:

- Allergies
- Conditions
- Discharge Summaries
- Discharge Instructions
- Hospital Visit Histories
- Lab Results
- Medication List
- Radiology Reports
- Upcoming Appointments

NEED LOGIN HELP?

- *I can't find my Medical Record/ Unit Number.*
- *I did not provide my email at the time of hospital registration and am receiving an enrollment unsuccessful message.*

Call Patient Portal Support at 855-870-5350 Monday - Saturday, 8am CDT - 10pm CDT

PATIENT PORTAL ENROLLMENT INSTRUCTIONS:

1. Enter your patient information (provided at registration) including your email address and Medical Record Number (MRN) or Unit Number*. (See the back of the brochure, Self Enrollment Form provided to you by hospital Registration or your Discharge Instructions.) If you need assistance, call Patient Portal Support at **1-855-870-5350**.
2. To complete the enrollment process, log into your e-mail account and open the 'Patient Portal Log In' email sent from noreply@mtpatientportal.com (If you can't find the email in your inbox, check your spam/trash/junk folders.)
3. Click the Patient Portal link in the email, input your temporary credentials and complete the Self Enrollment Questionnaire.
4. Log out and log back in to Patient Portal, this time using your newly created username and password.

Print Name: _____ Date: _____

Signature: _____

Volunteer Health Care Provider Program
2023 Federal Poverty Guidelines
48 Contiguous States and D.C.

Family Size	200% Poverty Annual Threshold	200% Monthly Income	150% Monthly Income	125% Monthly Income	100% Monthly Income
1	$29,160	$2,430	$1,823	$1,519	$1,215
2	$39,440	$3,287	$2,465	$2,054	$1,643
3	$49,720	$4,143	$3,108	$2,590	$2,072
4	$60,000	$5,000	$3,750	$3,125	$2,500
5	$70,280	$5,857	$4,393	$3,660	$2,928
6	$80,560	$6,713	$5,035	$4,196	$3,357
7	$90,840	$7,570	$5,678	$4,731	$3,785
8	$101,120	$8,427	$6,320	$5,267	$4,213
9	$111,400	$9,283	$6,963	$5,802	$4,642
10	$121,680	$10,140	$7,605	$6,338	$5,070
For each additional person, add 5,140	$10,280	$857	$643	$535	$428

SOURCE: Federal Register: January 24, 2023

Compiled by Chris Gainous
Volunteer Health Services
Florida Department of Health

1/24/2023