PLEASE FILL OUT ENTIRE FORM

SNYDER FAMILY CLEFT & CRANIOFACIAL CENTER AT WCH **PATIENT REGISTRATION FORM**

PATIENT INFORMATION

PATIENT'S LAST NAME:	FIRST:	MIDDLE:	DATE OF BIRTH:
EMAIL:	GENDER:	RACE:	HOME PHONE #:
ADDRESS: APT/UNIT:	CITY:	STATE:	ZIP CODE:
MOTHER/GUARDIAN FULL NAME:	CELL PHONE #: Is it ok to text with appointment reminders and event info? __ Yes __ No		
FATHER/GUARDIAN FULL NAME:	CELL PHONE #: Is it ok to text with appointment reminders and event info? __ Yes __ No		
MOTHER/GUARDIAN EMPLOYER:		WORK PHONE #:	
FATHER/GUARDIAN EMPLOYER:		WORK PHONE #:	
PRIMARY CARE PHYSICIAN:	PRIMARY CARE PHYSICIAN PHONE #:	PRIMARY CARE PHYSICIAN ADDRESS:	
PRIMARY CARE PRACTICE NAME:			
DENTIST:	DENTAL PHONE #:	DENTAL ADDRESS:	
DENTAL PRACTICE NAME:			

INSURANCE INFORMATION

IS THE PATIENT COVERED BY INSURANCE? □ YES □ NO

PLEASE INDICATE PRIMARY INSURANCE:	SUBSCRIBER'S NAME:	POLICY NO#:
NAME OF DENTAL INSURANCE (IF APPLICABLE):	SUBSCRIBER'S NAME:	POLICY NO#:

IN CASE OF EMERGENCY

NAME OF LOCAL FRIEND OR RELATIVE (NOT LIVING AT THE SAME ADDRESS):	RELATIONSHIP TO PATIENT:	PHONE #:

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I ALSO AUTHORIZE, THE SNYDER FAMILY CLEFT & CRANIOFACIAL CENTER OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRES TO PROCESS MY CLAIMS.

PATIENT/PARENT/GUARDIAN SIGNATURE DATE

Snyder Family Cleft & Craniofacial Center — at — Wolfson Children's Hospital

Consent and Authorization for Treatment – Adult Patient

I, _____, give my consent for the Snyder Family Cleft & Craniofacial Center at Wolfson Children's Hospital to examine, treat, and offer diagnosis. I give my consent for the Snyder Family Cleft & Craniofacial Center at Wolfson Children's Hospital to perform such medical care encompassing examination, diagnostic procedures, and medical treatment as deemed necessary. I acknowledge that no guarantees or assurances have been made as to the results of treatments or examinations. I recognize that the Snyder Family Cleft & Craniofacial Center at Wolfson Children's Hospital is a community effort consisting of private practice physicians, providers, contracted employees and students of other healthcare organizations. I recognize that my treatment may involve taking photographs. I authorize the Snyder Family Cleft & Craniofacial Center at Wolfson Children's Hospital to obtain and reproduce photographs for purposes of medical records and developing of a treatment plan. I understand that the Snyder Family Cleft & Craniofacial Center at Wolfson Children's Hospital uses photographs of children attending clinic for educational purposes only. By signing this form, I acknowledge that I have read this consent and agree to medical care by the Snyder Family Cleft & Craniofacial Center at Wolfson Children's Hospital.

_____

Signature of Patient Date Time

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices & Florida Patients' Bill of Rights and Responsibilities

Patient Name: _____ DOB: _____

I have been provided a copy of the Snyder Family Cleft & Craniofacial Center at Wolfson Children's Hospital HIPAA Notice of Privacy Practice and the Florida Patients' Bill of Rights. You have the right to receive a copy of these notices from the Snyder Family Cleft & Craniofacial Center at Wolfson Children's Hospital upon request. I understand that I may ask questions about this notice at any time and can contact the clinic at 904-202-4081.

_____

Signature of Patient Date Time

MEDICAL RECORDS REQUEST

Snyder Family Cleft & Craniofacial Center at Wolfson Children's Hospital

836 Prudential Drive Suite 807, Jacksonville, Fl. 32207 • 904-202-4081 phone • 904-202-3699 fax

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Snyder Family Cleft & Craniofacial Center at Wolfson Children's Hospital to use and/or disclose my protected health information (PHI) as provided below. I understand that I may revoke this authorization, but the revocation will not apply to information that has already been released in response to this authorization. The written revocation letter must be sent to Snyder Family Cleft & Craniofacial Center at Wolfson Children's Hospital. I understand that my child's treatment is in no way conditioned on whether or not I sign this authorization. I understand that once the PHI listed below is used or disclosed as set forth in this authorization, it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.

Patient Name _____ Date of Birth _____

Parent/Guardian Completing Form (Please Print) _____

Patient Address _____

City _____ State _____ Zip Code _____ Phone ( ) _____

FILL OUT FOR SNYDER FAMILY CLEFT & CRANIOFACIAL TO OBTAIN RECORDS:	**FILL OUT FOR SNYDER FAMILY CLEFT & CRANIOFACIAL TO DISCLOSE:**
I authorize _____ To disclose health information to: Snyder Family Cleft & Craniofacial Center 836 Prudential Drive Suite 807 Jacksonville, Fl. 32207 Contact Person: _____ Telephone: _____ Fax: _____	I authorize Snyder Family Cleft & Craniofacial Center to disclose health information to: Facility/Name: _____ _____ Address: _____ _____ Telephone: _____ Fax: _____
THE PURPOSE OF THIS DISCLOSURE OR USE IS: ☐ MEDICAL ☐ AT THE REQUEST OF PATIENT	METHOD OF DISCLOSURE: ☐ MAIL ☐ FAX

This request and authorization applies to:

☐ Healthcare information related to the following treatment, condition or dates: Any and all records related to Cleft/craniofacial care, birth records, surgical records, discharge summaries, immunization records, and dental x-rays.

☐ Other: _____

I understand that state law prohibits the use and/or disclosure of the PHI listed below unless specifically authorized. I understand that such information will not be used or disclosed in response to the above request unless indicated by initialing below:

Mental/Psychiatric: (initial)_____ HIV Tests/Related: (initial)_____ Alcohol/Substance Abuse: (initial)_____

THIS AUTHORIZATION AUTOMATICALLY EXPIRES TWO (2) YEARS AFTER IT IS SIGNED OR UNTIL I REVOKE IT IN WRITING TO THE SNYDER FAMILY CLEFT & CRANIOFACIAL CENTER AT WOLFSON CHILDREN'S HOSPITAL.

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Snyder Family Cleft & Craniofacial Center at Wolfson Children's Hospital

NO SHOW/MISSED APPOINTMENT POLICY

We understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel/reschedule appointments by calling the following number: **904-202-4081**.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. A reminder call and text is made prior to your visit. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the clinician's at the Snyder Family Cleft and Craniofacial Center at WCH and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.

2. If less than a 24-hour cancellation is given this will be documented as a "No-Show" appointment.

3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.

4. After the first "No-Show/Missed" appointment, you will receive a phone call or letter cautioning that you have broken our "No-Show" policy.

5. If you have 2 "No-Show/Missed" appointments within a one-year time period, you will receive a cautioning letter from our office.

6. If you have 3 "No-Show/Missed" appointments within a one-year time, you will be discharged and a referral from your primary care physician/pediatrician will be needed to return to our clinic.

To note: Many of our providers in their private practices have similar no show policies and will discharge the patient from the practice after 3 no shows. The patient will need to find another provider if this occurs. Please remember to call ahead of time to cancel the scheduled appointment.

I have read and understand the Snyder Family Cleft and Craniofacial Center at Wolfson Children's Hospital, No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify the Snyder Family Cleft and Craniofacial Center at Wolfson Children's Hospital appropriately if I have difficulty keeping my scheduled appointments.

_____ _____

Patient Name Date

_____ _____

Patient Signature or Parent/Guardian if minor Relationship to Patient

CONSENT TO BE VIDEOTAPED, PHOTOGRAPHED, RECORDED AND/OR INTERVIEWED (FOR NON-HEALTHCARE RELATED PURPOSES)

I, the patient indicated below, do hereby consent to be videotaped, photographed, recorded and/or interviewed while I am a patient of **Snyder Family Cleft & Craniofacial Center**, for one or more of the following purposes: education, advertising, social media, marketing, public relations, fundraising, and product or service promotion.

I understand that, once taken, such videotape, photographs, motion pictures, recordings and/or interview notes (the "Materials") will be the property of the journalist, reporter, interviewer, photographer, videographer or technician creating the Materials or the news agency or entity for which the Materials are created, including, but not limited to, donors to, business associates of, and vendors for, **Snyder Family Cleft & Craniofacial Center** (the "Recipient(s)") and that the Materials may be published at any time in or on any media, including, but not limited to, any circular, newsprint, catalog, brochure, publication, Internet or intranet web site or broadcast. I hereby waive any right that I may have to direct the use or publication of the Materials, and waive any claim I may have against **Snyder Family Cleft & Craniofacial Center** for payment or royalties in connection with any exhibition, televising or publication of the Materials, regardless of whether such exhibition, televising or publication is under philanthropic, commercial, institutional or private sponsorship.

For purposes of obtaining such Materials, I authorize **Snyder Family Cleft & Craniofacial Center** to allow the Recipient and any necessary assistant's reasonable access to me or my room and any other area where I will receive healthcare services. I release **Snyder Family Cleft & Craniofacial Center** and all team members associated with the clinic from any and all liability, including, but not limited to, defamation and invasion of privacy, which may arise from, or out of, the obtaining, use or publication of the Materials or their good faith reliance upon this Consent.

For the purpose of facilitating any such exhibition, televising or publication, or other marketing, public relations or media related use(s), I authorize **Snyder Family Cleft & Craniofacial Center** to release to the Recipient *limited* demographic and health information that is necessary, which is requested by the Recipient and which the Recipient indicates is reasonably necessary to accomplish such purpose. I understand that the release of information portion of this Consent shall expire one (1) year from the date hereof, but the remainder shall continue in full force and effect indefinitely. I further understand that the release of information portion of this Consent may be revoked by me in writing at any time, but that such revocation shall not apply to any release of information to the Recipient or by the Recipient that occurs prior to such revocation or to the extent that **Snyder Family Cleft & Craniofacial Center** or the Recipient has already relied upon this Consent. I agree to the terms of this Consent voluntarily, and understand that **Snyder Family Cleft & Craniofacial Center** has not, and will not, condition treatment on my signing this Consent. I understand that **Snyder Family Cleft & Craniofacial Center** has no control over the Recipient, so demographic and health information about me provided to the Recipient pursuant to this Consent may be re-disclosed by the Recipient and may no longer be protected by applicable State and federal privacy laws.

_____ _____

Signature of Patient (or Name of Patient if Signed Below) Date

_____

Printed Name of Patient

_____ _____

Address Phone

If (i) the patient is a minor, the patient's parent or guardian should consent by signing below, or (ii) if the patient is an adult but unable to consent for himself or herself, then the patient's guardian, legal representative, attorney-in-fact, surrogate or proxy should consent on the patient's behalf by signing below:

_____ _____

Signature of Representative Telephone

_____ _____

Printed Name Relationship to Patient

NOTE: THE ORIGINAL OF THIS DOCUMENT MUST BE INCLUDED IN THE PATIENT'S MEDICAL RECORD AND A COPY MUST BE PROVIDED TO THE PATIENT OR THE SIGNATOR ABOVE UPON REQUEST.

REV: 2/12/19