Cleveland Health Center

COMPREHENSIVE CARE FOR YOU

Welcome to Our Practice

Thank you for choosing Cleveland Health Center for your healthcare needs. We are committed to providing you with the highest quality, compassionate care.

Before Your Appointment

Please complete this New Patient Packet **prior to your appointment**. These forms are fillable and signable electronically, or you may print and bring them with you.

Please Bring the Following:

- Your current insurance card(s)
- A valid photo identification (Driver's License, State ID, or Passport)
- A list of your current medications

If you are unable to complete these forms in advance, please arrive **30 minutes early** to complete them in our office.

Cleveland Health Center

Patient Registration / Intake Form

Name (as it appears on insurance card)

Date of Birth

Patient Information

Patient's Legal Name (Last, First, M.I., Maiden)

Sex

☐ Male ☐ Female

Home Address (Street, City, State, Zip)

SSN (Last 4 digits)

Email Address

Marital Status

☐ S ☐ M ☐ D ☐ W

Home Phone

Cell Phone

Work Phone

Emergency Contact

Name (Last, First)

Relationship

Phone Number

If Patient Is A Minor

Father's Name

DOB

SSN (Last 4)

Address

Phone

Mother's Name

DOB

SSN (Last 4)

Address

Phone

Advance Directive Information

An Advance Directive is a written statement of your wishes regarding medical treatment (e.g., Living Will or Durable Power of Attorney), made to ensure those wishes are carried out should you be unable to communicate them.

I have completed an ADVANCE DIRECTIVE for health care: ☐ Yes ☐ No Initials: _____

If yes, indicate which:
- ☐ Living Will
- ☐ Durable Power of Attorney

I am requesting information regarding ADVANCE DIRECTIVES: ☐ Yes ☐ No Initials: _____

_____ _____

Patient / Guardian Signature | Date

Insurance Information

Primary Medical Insurance

Insurance Carrier

Carrier's Phone Number

Policy #

Group #

Subscriber Name

Subscriber SSN (Last 4)

Relationship to Patient

Secondary Medical Insurance

Insurance Carrier

Carrier's Phone Number

Policy #

Group #

Subscriber Name

Subscriber SSN (Last 4)

Relationship to Patient

Tertiary Medical Insurance (if applicable)

If You Are Currently Uninsured

Person Responsible for Payment

Name (Last, First, M.I.)

Relationship to Patient

Address (Street, City, State, Zip)

Certification Statement

I certify that the information above is true and accurate to the best of my knowledge. I understand that I am financially responsible for all charges whether or not paid by insurance.

Name of Patient (Print)

Name of Responsible Party (Print)

Signature of Patient / Responsible Party

Date

Responsible Party Driver's License #

Cleveland Health Center

Medical History Questionnaire

Today's Date | First Name | Last Name

Email | Birth Date | Sex

Height (in) | Weight (lbs) | Prescription refill needed today?

☐ Yes ☐ No

Pharmacy Name | Pharmacy City | Pharmacy Phone

Reason for seeing the doctor today:

Medical Providers Involved in Your Care

Provider Name	Specialty	Phone	Fax

+ Add additional providers on a separate sheet if needed

Allergies

List allergies to prescription medications with side effect / allergic reaction:

Medication	Side Effect / Allergic Reaction

+ Add additional allergies on a separate sheet if needed

Allergies to OTC medications or supplements (if any):

Current Prescription Medications

Name of Medication	Dose / Frequency	# Refills Left	Prescriber Name

+ Add additional medications on a separate sheet if needed

OTC medications and supplements:

Medical History – Conditions

Please check all conditions you have or have had. Use the "Other" field in each category to note any conditions not listed.

General

- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Prediabetes
- [ ] Diabetes
- [ ] Thyroid Disease

Other conditions in this category: _____

Heart & Vascular

- [ ] Coronary Artery Disease
- [ ] Heart Failure
- [ ] Heart Valve Disease
- [ ] Aneurysm of Aorta
- [ ] Peripheral Artery Disease
- [ ] Venous Insufficiency

Other conditions in this category: _____

Eyes / Ears / Mouth / Throat

- [ ] Cataracts
- [ ] Macular Degeneration
- [ ] Vision Loss
- [ ] Hearing Loss
- [ ] Vertigo
- [ ] Tinnitus
- [ ] Dysphagia (Swallowing Difficulty)

Other conditions in this category: _____

Genitourinary – Males

- [ ] Enlarged Prostate
- [ ] Erectile Dysfunction (ED)
- [ ] Prostate Malignancy
- [ ] Bladder Malignancy

Other conditions in this category: _____

Genitourinary – Females

- [ ] Overactive Bladder
- [ ] Urinary Incontinence
- [ ] Recurrent UTIs
- [ ] History of Blood in Urine
- [ ] History of GU Malignancies

Other conditions in this category: _____

Renal

- [ ] CKD (Chronic Kidney Disease)
- [ ] History of Kidney Stones

Other conditions in this category: _____

Lung

- [ ] Asthma
- [ ] COPD
- [ ] Emphysema
- [ ] Chronic Bronchitis
- [ ] Chronic Cough
- [ ] Sleep Apnea
- [ ] History of Lung Tumor

Other conditions in this category: _____

Gastrointestinal

- [ ] GERD (Reflux / Heartburn)
- [ ] Barrett's Esophagus
- [ ] IBS (Irritable Bowel Syndrome)
- [ ] Colitis
- [ ] History of Diverticulitis
- [ ] History of Colon Malignancy

Other conditions in this category: _____

Neuropsychological

- [ ] History of Stroke
- [ ] TIA
- [ ] Carotid Artery Disease
- [ ] Headaches
- [ ] Parkinson Disease
- [ ] Essential Tremor
- [ ] Seizure Disorder
- [ ] Multiple Sclerosis
- [ ] Reduced Memory
- [ ] ADHD
- [ ] Generalized Anxiety
- [ ] Depression
- [ ] Neuropathy

Other conditions in this category: _____

Immunology / Allergology

- [ ] History of Sinus Infections
- [ ] Chronic Allergies

Other conditions in this category: _____

Skin

- [ ] History of Melanoma
- [ ] Other Skin Malignancies

Other skin conditions: _____

Hematology / Oncology

- [ ] Anemia
- [ ] Low Platelets
- [ ] CLL

Other conditions in this category: _____

Musculoskeletal

- [ ] Polymyalgia Rheumatica
- [ ] Rheumatoid Arthritis
- [ ] Generalized Osteoarthritis
- [ ] Chronic Back Pain
- [ ] Spinal Stenosis
- [ ] Fibromyalgia
- [ ] Osteopenia
- [ ] Osteoporosis
- [ ] Muscle Weakness
- [ ] Leg Cramps
- [ ] Leg Muscle Pain with Exertion

Other conditions in this category:

Medical Tests, Procedures & Hospitalizations

Medical Tests / Procedures

Check the box if you have had the test. Indicate the year and outcome (e.g., normal / abnormal):

- ☐ Heart Catheterization _____
- ☐ Stress Test _____
- ☐ Colonoscopy _____
- ☐ Stool Cards _____
- ☐ EGD (Upper Endoscopy) _____
- ☐ DEXA _____
- ☐ CXR _____
- ☐ CT Scan of the Abdomen _____
- ☐ Ultrasound of the Aorta _____
- ☐ Kidney Ultrasound _____
- ☐ Mammogram _____
- ☐ Eye Exam (if diabetic) _____
- ☐ Foot Exam (if diabetic) _____
- ☐ PSA _____
- ☐ Other: _____

Hospitalizations and Surgeries

Year	Hospital Name, City and State	Reason / Type of Surgery
+ Add additional hospitalizations on a separate sheet if needed		

Family & Social History

Family History

Check the box if a close family member has had any of the following conditions. Indicate the approximate age of diagnosis:

Condition	Father	Mother	Sibling	Other Member	Age at Diagnosis
Heart Disease	☐	☐	☐		
Stroke	☐	☐	☐		
High Blood Pressure	☐	☐	☐		
Diabetes	☐	☐	☐		
Colon Malignancy	☐	☐	☐		
Breast Malignancy	☐	☐	☐		
Other Malignancies	☐	☐	☐		
Dementia / Alzheimer's	☐	☐	☐		
Depression	☐	☐	☐		
Alcoholism	☐	☐	☐		
Other: _____	☐	☐	☐		

Social History

Occupation (if retired, list previous occupation/s):

_____

Smoking history: ☐ None ☐ Current smoker ☐ Former smoker

If current: Packs/day ____ How long (years)? ____ If former: When did you quit? _____

Alcohol use: ☐ None ☐ Yes If yes, what kind and how often? _____

Illicit drug use? ☐ Yes ☐ No

Sexually active? ☐ Yes ☐ No

History of STDs? ☐ Yes ☐ No

Immunization History

Please indicate the date of vaccination:

Influenza (Flu shot)

_____

Prevnar 13 (new pneumonia shot)

_____

Pneumovax (regular pneumonia shot)

_____

Shingrix 1st dose

_____

Shingrix 2nd dose

_____

Zostavax (previous shingles vaccination)

_____

Td (tetanus vaccine)

_____

Tdap (Boostrix – tetanus & cough)

_____

Hepatitis A & B vaccine (Twinrix)

_____

General Consent & Authorizations

By checking the box and submitting (or signing below), I acknowledge and agree to the following:

Consent to Treatment

I voluntarily consent to medical evaluation and treatment provided by Cleveland Health Center and its healthcare professionals. This includes routine examinations, diagnostic testing, procedures, and medical care deemed necessary for my diagnosis and treatment. I understand that no guarantees are made as to treatment outcomes and that I may ask questions or decline treatment at any time.

Assignment of Insurance Benefits

I authorize my insurance company to pay medical benefits directly to Cleveland Health Center for services rendered. I understand that I am financially responsible for any charges not covered by insurance, including copayments, coinsurance, deductibles, or non-covered services. I authorize the release of medical or billing information as needed to process insurance claims.

Consent to Receive Communications

I consent to receive communications from Cleveland Health Center via phone calls, voicemail, text messages, and email regarding my care, appointments, billing, and administrative updates. I understand automated technology may be used and that standard messaging/data rates may apply. I may opt out at any time by notifying the office.

Telemedicine Informed Consent

I consent to receive medical services via telemedicine when appropriate. I understand that telemedicine may include remote communication and videoconferencing. I acknowledge the risks and limitations of telemedicine, including potential technical issues, and I understand that I may discontinue or request in-person care at any time. My rights to confidentiality and privacy apply equally to telemedicine services.

Non-Covered & Elective Services Acknowledgment

I understand that Cleveland Health Center may offer elective or non-covered services, including wellness and aesthetic treatments, which are not eligible for insurance reimbursement. I acknowledge that I am fully responsible for payment of such services and that these charges will not be billed to or reimbursed by my insurance provider.

Acknowledgment & Electronic Signature

By checking the box and submitting (or signing below), I confirm that I have read and understand this General Consent & Authorizations and agree to its terms. I acknowledge that I was offered access to the Notice of Privacy Practices, available at the front desk and on the practice website.

☐ **I HAVE READ AND UNDERSTAND THE GENERAL CONSENT & AUTHORIZATIONS AND AGREE TO THE TERMS ABOVE.** **(Required)**

Patient Name (print) _____ **Date of Birth** _____

_____

Signature of Patient or Legal Guardian (type full legal name or sign)

Print Name of Patient or Legal Guardian _____ **Date** _____

Relationship to Patient (if guardian)

_____

Cleveland Health Center

Authorization to Disclose Health Information

1. Patient Information

Name (First, Middle, Last)

CHC Medical Record # (if known)

Current Address (Street, City, State, Zip)

Last 4 Digits of SSN

Email

Phone Number

Date of Birth

2. Release Information From

Facility / Provider

Address (Street, City/State, Zip)

Phone Number

3. Release Information To: Cleveland Health Center

Cleveland Health Center

Address: 5463 Spencer Court **City/State/Zip:** Wildwood, Florida 34785 **Phone:** (352) 353-0092 **Fax:** (352) 353-0416

Delivery method:

- ☐ Paper
- ☐ Secure electronic delivery

Purpose of Disclosure:

- ☐ Continuity of Care
- ☐ Other: _____

Dates of service to release (FROM) **(TO)**

_____ _____

Records to Release:

- ☐ Office Visits
- ☐ History & Physical
- ☐ Emergency Dept Reports
- ☐ Other: _____
- ☐ Discharge Summary
- ☐ Other: _____
- ☐ Operative Reports
- ☐ Other: _____

I, the undersigned, authorize the above named sending Facility/Provider as described in Section 2 to release health information as indicated above. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse. **This authorization does not include permission to release outpatient Psychotherapy Notes.** Release of Psychotherapy Notes requires a separate authorization.

This authorization will expire one year from the date written below, unless revoked in writing. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization. **If Authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.**

Signature of Patient / Patient's Personal Representative

Date Signed

Printed Name

Relationship, if not Patient

Submit completed request to the Cleveland Health Center Facility identified in Section 3 above. NOTICE: If you send health information via email, please know that your message may be sent in an unencrypted email and could potentially be read by a third party. Revision: 01/2026

Financial Policy

Effective Date: January 1, 2026 | Last Updated: February 21, 2026

Thank you for choosing Cleveland Health Center. This Financial Policy explains your financial responsibilities for services provided by our practice. Please read it carefully.

I. Definitions

- **Patient:** The individual receiving care.
- **Responsible Party:** The person financially responsible for charges.
- **Proof of Insurance:** A valid, current insurance card.
- **Self-Pay / Uninsured:** No active health coverage.
- **Out-of-Network:** Your insurance plan is not contracted with our practice.
- **Patient Responsibility:** Amounts due after claim processing or for non-covered services.

II. Insurance Coverage & Proof of Insurance

Insurance information is required at each visit. Verification is not a guarantee of payment. Your plan rules apply; you are responsible for understanding your benefits, limitations, referral requirements, prior authorizations, network status, and coverage determinations. If insurance information is missing or incorrect, you may be responsible for the full cost of services.

III. Copayments, Deductibles & Coinsurance

Copayments are due prior to services. Deductibles and coinsurance are the Patient's responsibility and are due when billed.

IV. Out-of-Network Plans

If we are out-of-network with your plan, payment is due at the time of service unless other arrangements are made in advance in writing. Reimbursement from your insurer is not guaranteed.

V. Non-Covered / Elective Services

Some services may be non-covered, elective, or not medically necessary. You are responsible for full payment for such services at the time of service or in advance.

VI. Self-Pay, Deposits & Estimates

Self-pay patients may receive discounted rates. Full payment is due at the time of service. Deposits required: **New patients: $300 minimum**; **Established patients: $150 minimum**. You may request a Good Faith Estimate. A card on file may be required to cover remaining balances.

VII. Payment Methods & Convenience Fee

Accepted forms: cash, personal check, and credit/debit cards. Card payments may incur a **$2.00 convenience fee** where permitted by law.

VIII. Returned Payments

Returned checks are subject to a **$25 fee**. Future payments must then be made by cash, card, or money order.

IX. Billing, Statements & Collections

Remaining balances are due upon receipt of a statement. If payment is not received within **60 days**, the account may be referred to a collection agency or attorney. Unpaid balances may result in scheduling restrictions or dismissal from the practice.

X. Third-Party Liability & Denials

We do not bill third-party liability carriers (auto, workers' comp, etc.). If a claim is denied or down-coded, you are responsible for the balance.

XI. Administrative Services & Records Fees

Medical records fees: **$1.00/page** (up to 50 pages), **$0.50/page** (over 50 pages), **$15** for itemized bills, **$20** for USB/CD.

XII. Missed Appointments & Cancellation Fees

We require at least **48 business hours' notice** to cancel or reschedule. Fees: **$100** for office visits, **$200** for diagnostic/procedure appointments. These fees are not billable to insurance.

XIII. Financial Hardship & Minor Patients

Payment plans may be offered at the discretion of practice leadership. A parent or legal guardian must accompany minors at their first visit and is the Responsible Party.

Acknowledgment & Electronic Signature

☐ **I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY AND AGREE TO ABIDE BY ITS GUIDELINES.** **(Required)**

Name of Insured / Subscriber (Primary)

Patient Date of Birth

☐ Same as Patient

Signature of Patient or Legal Guardian (type full legal name or sign)

Print Name of Patient or Legal Guardian

Date

Relationship to Patient (if guardian)

Notice of Privacy Practices (HIPAA)

Effective Date: January 1, 2026 | www.myclevelandhealthcenter.org | (352) 353-0092

This Notice describes how medical information about you may be used and disclosed, and how you can get access to this information. At Cleveland Health Center, your privacy is a priority. We are committed to protecting the confidentiality of your health information in accordance with HIPAA and Florida law.

Uses and Disclosures Without Authorization

We may use or disclose your Protected Health Information (PHI) for:

- **Treatment:** To coordinate and provide medical care.
- **Payment:** To bill insurance and obtain payment.
- **Healthcare Operations:** For administrative and operational purposes.
- **Persons Involved in Your Care:** In emergencies or if you do not object.
- **Business Associates:** Contractors bound by confidentiality agreements.
- **Public Health & Safety:** Reporting diseases, preventing injury, etc.
- **Legal Purposes:** Court orders, subpoenas, law enforcement.
- **Appointment Reminders:** To contact you regarding services.

Uses Requiring Written Authorization

- Psychotherapy Notes
- Marketing communications
- Sale of PHI
- Genetic Information (for underwriting)

You may revoke any authorization in writing at any time.

Your Rights Regarding Your PHI

- **Right to Access:** Inspect and request copies of records.
- **Right to Amend:** Request amendments with justification.
- **Right to an Accounting:** List of disclosures outside of treatment/payment.
- **Right to Request Restrictions:** On how we use/disclose PHI.
- **Right to Confidential Communications:** Via specific methods.
- **Right to a Paper Copy:** Even if received electronically.
- **Right to Notification of Breach:** If unsecured PHI is breached.

Complaints

If you believe your rights have been violated, you may file a complaint with the Cleveland Health Center Privacy Officer at **info@myclevelandhealthcenter.org** or the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

Acknowledgment of Notice of Privacy Practices

I acknowledge that I have been offered access to Cleveland Health Center's Notice of Privacy Practices, effective January 1, 2026, which explains how my health information may be used and disclosed and how I may access that information. A copy is available upon request and at **www.myclevelandhealthcenter.org**.

Patient Name _____ **Date of Birth** _____

_____ _____

Signature Date

If signed by Authorized Representative (if applicable):

Representative Name _____ **Relationship to Patient** _____

_____ _____

Signature Date