



Escambia Community Clinics, Inc.

2200 N. Palafox Street
Pensacola, Florida 32501
(850) 436-4630

Dear Patient,

Welcome to Escambia Community Clinics, Inc. We look forward to serving your healthcare needs. To make your registration as smooth as possible, please complete the enclosed documents prior to your appointment.

- Registration Form
- Permission for Treatment
- Proof of insurance (if any is available)
- If no health insurance is available, please review the link under programs and services regarding our Sliding Fee Scale services

Please bring the following documents with you:

- Driver's License or Photo ID
- Social Security Card
- Insurance card(s) (if any is available)

To ensure a pleasant visit please:

- Arrive thirty minutes early for your ***first appointment***.
- Give 24 hours notice if you cannot keep an appointment
- Call if you are going to be late, we may need to reschedule your appointment
- **Bring ALL** of your medications with you

Services Available to you are:

- Prescription Assistance Program (If Eligible)
- Social Services
- Case Management
- Women's Health

No Show Policy

If you miss more than three scheduled appointments without calling and canceling, you may lose your status as an established patient with ECC. This would include being discharged from Sliding Fee Scale Program and Primary Care.

Please feel free to call 436-4630 with any questions regarding these forms.

Sincerely,

Escambia Community Clinics, Inc.

Patient Registration Form

PATIENT NAME: _____

ADDRESS: _____
(Street) (City) (State) (Zip)

PHONE: (Home) _____ (Cell) _____

SEX: _____ DOB: _____ SS# _____ Marital Status: _____

African American Caucasian Asian More than one race

Native Hawaiian/ Other Pacific Islander American Indian/ Alaska Native

Are you Hispanic? Yes No (please circle one)

SPOUSE'S NAME: _____

EMERGENCY CONTACT: _____ PHONE: _____

Does Patient have any type of medical insurance?

_____ Medicaid _____ Share of Cost _____ Medicare _____ Other

Under penalty of law, I declare the information contained on this form to be true and correct and consent to the verification of this information by ECC. I also authorize ECC to release any information to any insurance company, the Florida Division of Family Services, Center for Medicare Services or any of their respective agencies that I may have designated as providing insurance in order to secure payment for any treatment provided by ECC.

Signature _____ Date: _____

Office Use Only

Patient Classification _____ Approved for \$5.00 Fee Status

_____ Approved for Sliding Fee Scale Percentage

Escambia Community Clinics, Inc
2200 North Palafox Street*Pensacola, Florida 32501

RELEASE OF MEDICAL INFORMATION

I acknowledge that records concerning the patient are the property of Escambia Community Clinics, Inc (ECC) and are maintained for the use and benefit of ECC and its medical staff. I authorize ECC to disclose all or any part of my patient record to any person or corporation which is or may be liable under contract to the Clinic or to me or to a family member of mine for all or part of the charges including but not limited to the Clinic's medical insurance company, worker's compensation carriers or welfare agencies provided such release of information is in accordance with federal and state laws.

ASSIGNMENT OF INSURANCE BENEFITS

I assign payment of all insurance benefits, basic and major medical for this period of medical treatment, to be made directly to ECC.

FINANCIAL AGREEMENT

For and in consideration of services rendered, each of the undersigned agrees to pay ECC for all charges not covered by insurance payment as statements are rendered. Further, should it become necessary to enforce collection of any unpaid balance for medical services or treatment rendered, each of the undersigned agrees to pay all collection and legal expenses incurred by the clinic including reasonable attorney's fees which shall include, but not be limited to, such fees incurred prior to.

STATEMENT OF PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENT

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by or in ECC, including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits or benefits for related services.

STATEMENT OF PERMIT PAYMENT OF MEDIGAP BENEFITS TO PROVIDER, PHYSICIANS AND PATIENT

I request that payment of authorized Medigap benefits be made either to me or on my behalf of ECC for any services furnished me. I authorize any holder of medical information about me to release to my Medigap insurance carrier any information needed to determine these benefits or the benefits payable for related services.

AUTHORIZATON FOR MEDICAL CARE AND TREATEMNT

The undersigned hereby make the following Acknowledgments and Agreements regarding the medical treatment to be provided to the patient whose name appears on the reverse side hereof.

- I recognize that a condition exists requiring medical care and do hereby voluntarily consent to such medical care encompassing diagnostic procedures and medical treatment at Escambia Community Clinics, Inc. as is deemed necessary. I understand that this medical care may include tests, examinations and medical treatment.
- I am aware that the practice of medicine and surgery and the administration of medical care are not exact sciences and acknowledge that no guarantees have been made to me as to the result of diagnostic procedures, surgical procedures, medical procedures, treatments, examinations or care undertaken by ECC.
- I understand that such medical care, treatment and procedures will be performed by independent physicians and by employees of ECC between the hours of 8:00 a.m. and 8:00 p.m. only. I understand that no responsibility will be taken by ECC for long term patient care, or between 8:00 p.m. and 8:00 a.m.

This form has been fully explained to me and I certify that I understand its contents.

Printed Name

Signature of Patient

Print Parent name or Guardian if Minor

Signature of Parent or Guardian if Minor

Print Name of Parent or other representative

Signature of Parent or other representative

Patient's Date of Birth

Today's Date