MAIN 727.826.0700 • FAX 727.954.6994
info@lovethegoldenrule.com

New Patient Packet

Welcome to Love The Golden Rule, Inc.

We are pleased that you have chosen our practice for your healthcare needs. This packet contains the forms that establish your patient record, consent for treatment, communication preferences, and financial responsibilities. Please complete every section and return the packet to our front desk. If you have any questions, please call us at 727-826-0700.

Patient Portal & Telehealth

Stay connected with your care by downloading the Healow app. View appointments, message our team, review records, and manage medications from your phone.

HOW TO GET STARTED WITH HEALOW

1. Download the app. Search "Healow" on the App Store or Google Play.
2. Tap "Get Started." Review and accept the Terms & Conditions.
3. Enter your information. First name, last name, and date of birth, then tap Continue.
4. Enter our practice code: **BJJCDD**. Select Love The Golden Rule, Inc. and tap "This Is My Practice."
5. Verify your identity. Receive a code by text, call, or email and enter it.
6. Create a 6-digit PIN to secure your account.

With Healow you can: book or view appointments, set reminders, message our office securely, and access personal and family health information anytime.

Patient Registration

A. PERSONAL INFORMATION

Today's Date _____ Date of Birth _____

SSN _____

Legal Last Name _____ First _____

Middle _____

Chosen / Affirmed Name (if different) _____

Pronouns _____

B. CONTACT INFORMATION

Address _____

Apt/Unit _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

EMERGENCY CONTACT

Name _____ Relationship _____

Cell Phone _____ Home Phone _____

How did you hear about us? _____

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C. DEMOGRAPHIC INFORMATION

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Other

Gender Identity: ☐ Cisgender Male ☐ Cisgender Female ☐ Non-Binary ☐ Two Spirit
☐ Transmasculine / Transgender Man ☐ Transfeminine / Transgender Woman ☐ Intersex ☐ Agender
☐ Gender Non-Conforming ☐ Prefer Not to Disclose ☐ Other: _____

Marital Status: ☐ Married ☐ Divorced ☐ Partnered ☐ Single ☐ Widowed ☐ Legally Separated

Preferred Language _____ Need a Translator? ☐ Yes ☐ No

Race: ☐ Asian ☐ Black / African American ☐ Haitian ☐ Pacific Islander ☐ White ☐ Other:
_____

Ethnicity: ☐ Cuban ☐ Hispanic / Latino ☐ Latin American ☐ Mexican ☐ Not Hispanic / Latino
☐ Puerto Rican ☐ Prefer Not to Disclose ☐ Other: _____

Patient Financial Responsibility Acknowledgment

Do you have health insurance? ☐ Yes ☐ No

Provider _____ Member ID _____

Provider / Customer Service Number _____

I acknowledge that I am responsible for payment of services rendered, which may include:

- Co-pays, deductibles, co-insurances, and non-covered charges
- Balances not paid by my insurance plan (if my plan does not participate with LTGR)
- Full payment at the time of service if I am uninsured or self-pay

I also understand that:

- I must update LTGR with any changes in my insurance information
- I may be eligible for financial assistance programs (e.g., the Sliding Fee Discount Program) pending income verification

☐ I wish to apply for financial assistance. ☐ I decline financial assistance at this time.

_____ _____
Patient / Guarantor Signature Date

ASSIGNMENT OF BENEFITS (THIRD PARTY PAYERS)

I assign to LTGR all benefits provided under my healthcare plan. I understand that I am responsible for any charges not covered by this assignment.

_____ _____
Patient / Representative Signature Date

MEDICARE PATIENTS ONLY — CERTIFICATION, AUTHORIZATION & ASSIGNMENT OF BENEFITS

I certify that the information provided is correct and authorize LTGR to release my medical information to Medicare or its intermediaries / carriers. I assign benefits payable for physician's services to LTGR.

_____ _____
Patient / Representative Signature Date

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Initiation of Services & Consent to Treatment

I consent to enter a patient–provider relationship with Love The Golden Rule, Inc. I authorize LTGR and its representatives to provide medical and / or behavioral health services. I understand that:

- Medical Care may include office / telehealth visits, obtaining medical history, physical examinations, medication administration, laboratory tests, and minor procedures.
- Behavioral Health Care may include individual, couple, or group therapy sessions.

This relationship is confidential and voluntary. I understand that I may discontinue services at any time.

Printed Patient Name _____

_____ _____
Patient Signature Date

Printed Representative / Guardian Name _____

_____ _____
Representative / Guardian Signature (if applicable) Date

Disclosure of Information Consent

I consent to the use and disclosure of my medical information—including photographic images, laboratory tests, and case management details—for treatment, payment, research, quality improvement, and healthcare operations. Substance Use Disorder information will be disclosed only in accordance with applicable Federal Regulations (42 CFR Part 2).

_____ _____
Patient / Representative / Guardian Signature Date

Notice of Privacy Practices

I acknowledge that I have received the LTGR Notice of Privacy Practices, which explains how my healthcare information may be used and disclosed. I understand that I may contact the Compliance Officer with any questions or concerns. (Print copy available upon request.)

_____ _____
Patient / Representative / Guardian Signature Date

Telehealth Guidelines

For telehealth appointments, please ensure that you:

- Have a secure, private location
- Possess a reliable internet connection
- Log in 15 minutes early to troubleshoot any technical issues
- Understand that telehealth visits may limit certain diagnostic tests and physical examinations
- Acknowledge responsibility for any co-pays associated with the appointment
- Provide at least 24 hours' notice to cancel or reschedule
- Understand that repeated no-shows may lead to scheduling restrictions or dismissal from the practice

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Consent to Access Care Information

I authorize LTGR staff to communicate with the following individual(s) regarding my care (appointments, billing, and other care-related matters):

CONTACT 1

Name _____ Relationship _____

Contact Number _____

CONTACT 2

Name _____ Relationship _____

Contact Number _____

I understand that I may revoke this authorization in writing at any time.

Communication Preferences

I consent to receive appointment reminders and healthcare communications by the following methods:

Voice Messages — At Home: ☐ Yes ☐ No On Cell Phone: ☐ Yes ☐ No

Text Messages: ☐ Yes ☐ No Email: ☐ Yes ☐ No

I understand that all electronic communications are recorded as part of my medical record. I may revoke this consent at any time.

_____ _____

Patient Signature Date

_____ _____

Representative / Guardian Signature (if applicable) Date

Authorization to Release Medical Records

I authorize Love The Golden Rule, Inc. (LTGR) to disclose or receive the following protected health information:

☐ Complete Medical Records ☐ Progress Notes ☐ Diagnostic Imaging and Lab Results
☐ Billing Statements

Other: _____

Purpose of Disclosure (check all that apply): ☐ Continuity of Care ☐ Personal Use ☐ Legal
☐ Insurance ☐ Other: _____

RELEASE TO / OBTAIN FROM

Name / Organization _____

Address _____

Phone _____ Fax _____

Date Range of Records: ☐ All ☐ From: _____ To: _____

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I understand that this authorization is voluntary and can be revoked in writing at any time, except where disclosure has already occurred. This authorization will remain valid for one year from the date of signature unless otherwise specified here: _____ .

I understand that records disclosed may include information related to mental health, substance use, HIV/AIDS, and reproductive health unless otherwise specified below:

☐ Do NOT release the following: _____

Printed Patient Name _____

Patient Date of Birth _____

_____ _____
Patient Signature Date

Printed Representative / Guardian Name _____

Relationship to Patient _____

_____ _____
Representative / Guardian Signature (if applicable) Date

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New Patient Medical History

Please complete to the best of your knowledge.

Full Name _____ Date _____

Birth Date _____ Age _____

ALLERGIES ☐ NO KNOWN ALLERGIES

Allergy	Allergic Reaction

CURRENT MEDICATIONS

Medication Name	Dose	Frequency

If more space is needed, please attach a list.

PREFERRED PHARMACY

Pharmacy Name	Location #	Address	Phone	Fax

HEALTH MAINTENANCE SCREENING HISTORY

Test	Date	Facility / Provider	Abnormal Result?
Cholesterol			☐ Yes ☐ No
Colonoscopy / Sigmoidoscopy			☐ Yes ☐ No
Mammogram			☐ Yes ☐ No
Pap Smear			☐ Yes ☐ No
Bone Density			☐ Yes ☐ No

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VACCINATION HISTORY

Last Tetanus Booster or Tdap		Last Pneumovax (Pneumonia)	
Last Flu Vaccine		Last Prevnar	
Last Zoster Vaccine (Shingles)			

SPECIALIST CARE

Provider Name	Specialty	Last Visit Date	Phone

Personal Medical History

Disease / Condition	Current	Past	Comments
Alcoholism / Drug Use	☐ Yes ☐ No	☐ Yes ☐ No	
Asthma / COPD	☐ Yes ☐ No	☐ Yes ☐ No	
Cancer (Type: _____)	☐ Yes ☐ No	☐ Yes ☐ No	
Depression / Anxiety	☐ Yes ☐ No	☐ Yes ☐ No	
Diabetes (Type: _____)	☐ Yes ☐ No	☐ Yes ☐ No	
Heart Disease / High BP / High Cholesterol	☐ Yes ☐ No	☐ Yes ☐ No	
Kidney Disease	☐ Yes ☐ No	☐ Yes ☐ No	
Migraines	☐ Yes ☐ No	☐ Yes ☐ No	
Stroke / TIA	☐ Yes ☐ No	☐ Yes ☐ No	
Thyroid Issues	☐ Yes ☐ No	☐ Yes ☐ No	
Other: _____	☐ Yes ☐ No	☐ Yes ☐ No	
Other: _____	☐ Yes ☐ No	☐ Yes ☐ No	

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Hospitalizations & Surgeries

Year	Reason / Procedure	Facility

Family Medical History

For each condition, check the family members it applies to. MGM = Maternal Grandmother, MGF = Maternal Grandfather, PGM = Paternal Grandmother, PGF = Paternal Grandfather.

Condition	Mother	Father	Brother	Sister	Child	MGM	MGF	PGM	PGF	Other
Alcohol / Drug Abuse										
Asthma										
Cancer (type)										
Emphysema / COPD										
Depression / Anxiety										
Bipolar / Suicidal										
Diabetes										
Early Death										
Heart Disease										
High Cholesterol										
High Blood Pressure										
Kidney Disease										
Stroke										
Thyroid Disease										
Migraines										
Other										

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Social & Lifestyle History

Tobacco Use: ☐ Never ☐ Former ☐ Current packs/day: _____ for _____ years
Alcohol Use: ☐ None ☐ Occasional ☐ Regular drinks/week: _____
Drug Use: ☐ Yes ☐ No Type: _____
Occupation _____ Employment: ☐ Full-time ☐ Part-time ☐ Retired ☐ Other
Relationship Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed
Children: ☐ Yes How many? _____ ☐ No
Exercise: ☐ Yes ☐ No Type: _____ Frequency: _____
Duration: _____
Diet: ☐ Good ☐ Fair ☐ Poor Would like nutrition advice? ☐ Yes ☐ No
Advance Directive / Living Will in place? ☐ Yes ☐ No
Safety: Smoke detectors at home? ☐ Yes ☐ No Seatbelts / Helmets used? ☐ Yes ☐ No
Have you traveled outside of the country in the last 30 days? ☐ Yes ☐ No

Additional Information or Concerns

Please list anything else we should know to support your care:

_____ _____
Patient or Guardian Signature Date