Love The Golden Rule, Inc.
Main: 727-826-0700
Fax: 727 -954-6994
Email: Info@lovethegoldenrule.com

LOVE THE GOLDEN RULE, INC.

New Patient Packet

Welcome & Introduction

Welcome to Love The Golden Rule, Inc. We are pleased that you have chosen our practice for your healthcare needs. This packet contains important forms that establish your patient record, consent for treatment, communication preferences, and financial responsibilities. Please complete all sections and return the completed packet to our office at your earliest convenience. For any questions, contact our front desk.

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Patient Portal & Telehealth Information

Patient Portal

Stay Connected With Your Care — Download the Healow App Today!

📱 Take control of your health in just a few steps.
With the Healow app, you can view appointments, send messages, check records, and stay on top of medications—all from your phone.

🔹 How to Get Started
STEP 1: Download the App
Search “Healow” on the App Store or Google Play
Install the app to your device.

STEP 2: Tap "Get Started"
Review and accept the Terms & Conditions.

STEP 3: Enter Your Info
Type in your First Name, Last Name, and Date of Birth
Tap Continue

STEP 4: Enter Our Practice Code
📌 Use code: BJJCDD
Select Love The Golden Rule, Inc as your provider
Tap “This Is My Practice”

STEP 5: Verify Your Identity
Choose to receive a verification code via text, call, or email
Enter the code and proceed

STEP 6: Create a PIN
Set a secure 6-digit PIN to access your account moving forward

💡 What You Can Do With Healow:
✅ Book or view appointments
✅ Set up medication and appointment reminders
✅ Communicate with our office securely
✅ Access personal and family health info anytime
📞 Need help? Call us at 727-826-0700

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Patient Registration Form

A. Personal Information

Today's Date: _____ **Date of Birth:** _____ **SS#:**_____

Legal Name: Last: _____ 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? _____

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: _____

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Patient Financial Responsibility Acknowledgment

Health Insurance: 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

Patient/Guarantor Signature: _____ **Date:** _____

Please indicate:

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

Assignment of Benefits *(For 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:** _____

For Medicare Patients Only

Medicare 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. 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:** _____

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Telehealth Guidelines

For telehealth appointments, please ensure 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
- Please provide at least 24 hours' notice to cancel or reschedule.
- Repeated no-shows may lead to scheduling restrictions or dismissal from the practice.

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 via 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:** _____

Love The Golden Rule, Inc.
Nonprofit Medical Clinic

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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: _____

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: _____

Love The Golden Rule, Inc.
Nonprofit Medical Clinic

NEW PATIENT MEDICAL HISTORY FORM

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.)

PREFFERED PHARMACY

Pharmacy Name	Location #	Address	Phone Number	Fax Number

HEALTH MAINTENANCE SCREENING TEST HISTORY

Test	Date	Facility/Provider	Abnormal Result? Y N
Cholesterol			Y N
Colonoscopy/Sigmoid			Y N
Mammogram			Y N
Pap Smear			Y N
Bone Density			Y N

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 Number

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Nonprofit Medical Clinic

PERSONAL MEDICAL HISTORY

Disease/Condition	Current	Past	Comments
Alcoholism / Drug Use	☐	☐	
Asthma / COPD	☐	☐	
Cancer (Type: _____)	☐	☐	
Depression / Anxiety	☐	☐	
Diabetes (Type: _____)	☐	☐	
Heart Disease / High BP / High Cholesterol	☐	☐	
Kidney Disease	☐	☐	
Migraines	☐	☐	
Stroke / TIA	☐	☐	
Thyroid Issues	☐	☐	
Other: _____	☐	☐	
Other: _____	☐	☐	

HOSPITALIZATIONS AND SURGERIES

FAMILY MEDICAL HISTORY

✓ CHECK ALL THAT APPLY	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:	Other:	Other:
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
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? Y N

ADDITIONAL INFORMATION OR CONCERNS

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

_____

_____

Patient or Guardian Signature: _____ Date: _____