Peace River Center®
COMPASSIONATE PEOPLE • POSITIVE IMPACT

PRC Staff only
Appt. Date: _____
With: _____
Time: _____

**Registration Form for Child**

**Patient Information:**

First Name: _____ Middle Name: _____

Last Name: _____ Preferred Name: _____

Client ID: _____ Social Security # (no dashes) _____

DOB: _____ Age: _____ Gender: ☐ Female or ☐ Male

Address: _____

City: _____ Zip Code: _____ County: _____

Primary Phone: _____ Alternate Phone: _____

Primary Language: _____ Interpreter Needs: _____

Ethnicity: _____ Race: _____ If Hispanic, specify: _____

**Parent/Guardian Information:**

First Name: _____ Preferred Name: _____

Last Name, If Different Than Above: _____ Do you want a reminder call: ☐ Yes or ☐ No

Primary Phone, If Different Than Above: _____

Address, if different than above: _____

Primary Language: _____ Interpreter Needs: _____

Parent/Guardian E-mail Address: _____

Occupation? ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled Monthly Income: _____

Household Size: _____ Insurance: _____

Date Received: _____ Received From: _____

Referral Source: _____

Referral Description: _____

Primary Care Physician's Information: _____

Parent/Guardian Signature: _____ Date: _____

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**Continued: Demographic Data**

**What does your child consider themselves to be?** ☐ Decline to Answer/Not Applicable

☐ Male ☐ Female

☐ Transgender (male to female) ☐ Transgender (female to male)

☐ Gender non-conforming

**Does your child think of yourself as?** ☐ Decline to Answer/Not Applicable

☐ Straight or Heterosexual ☐ Homosexual (gay or lesbian) ☐ Bisexual

☐ Pansexual ☐ Questioning ☐ Asexual ☐ Other:_____

**Is your child Hispanic, Latino/a, or of Spanish origin?** ☐ Yes ☐ No ☐ Decline to answer

**If yes,** please select all that apply:

☐ Central American ☐ Cuban ☐ Dominican ☐ Mexican ☐Puerto Rican ☐ South American

☐ Other:_____

**Race** (Please select all that apply) ☐ Decline to answer

☐ Black/African American ☐ White ☐ American Indian ☐ Alaskan Native ☐ South Asian

☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐Native Hawaiian

☐ Guamanian or Chamorro ☐ Samoan ☐ Other: _____

**[If client is 5 years and up] Do does your child speak a language other than English at home?**

☐ Yes ☐ No ☐ Decline to answer

**If yes,** what is the language? _____

Parent/Guardian Signature: _____ Date: _____

# Primary Care Physician

**PCP:**_____

(*First Name and Last Name of Primary Care Physician*):

**Address:** _____

**City:** _____ **Zip code:**_____

**Telephone number:** _____

**Fax Number:** _____

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## Child General Consents/AOB

I have Legal custody of this Child ___ Yes ___ No

### Patient Consents

*I give permission to contact me and/or my child/ward's Primary Care Physician for the purpose of follow-up care. I have been informed of the importance of these contacts as ways to improve continuity of care. I realize I have the right to revoke this consent at any time.
*I will notify Peace River Center if my child/ward's address or telephone numbers are changed.
*I give permission for my child/ward_____ to receive services from Peace River Center.
*I give my consent for Peace River Center to provide my child/ward with services.
*I understand that I must inform my child/ward's primary therapist when they are receiving other mental health services, either from within Peace River Center or from a practitioner outside of the Center.
*I understand that if now or in the future my child/ward has a relative who is employed by Peace River Center it is strongly recommended that my child/ward receives service through another provider. I may, however, request and receive services for my child/ward at Peace River Center with the understanding that my child/ward's case will receive no special privileges and will be handled following regular policies and procedures.
*I consent to having my child/ward's picture taken and stored on their page of the Electronic Medical Record for Peace River Center.
***I consent to being contacted by the following methods:** Phone, Email, Text
**My Preferred method of communication is (choose one or more):** ___Phone ___Email ___Text ___None
*I consent to receive calls/texts/emails from Peace River Center for my child/ward's protected healthcare and other services at the contact information provided, including my wireless number. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

I acknowledge that I have read the consents as a parent/legal guardian of a patient of Peace River Center and I understand them. ___ Yes ___ No

### HIPAA Acknowledgement

I acknowledge that I was provided a copy of Peace River Center's Notice of Privacy Practices to meet the HIPAA requirements under 45 CFR 164.520 (c) (2) (I), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices and agree to its terms. ___ Yes ___ No

### Health Information Exchange (HIE) Consent/Opt-Out

Peace River Center participates in a Health Information Exchange (HIE), which allows your child/ward's medical information to be available and viewed electronically by external healthcare providers. The HIE is designed to provide quick access to medical records to make treatment more effective and efficient. Any authorized healthcare provider and their medical team who agree to participate in the HIE can electronically access and use your child/wards protected health information, if needed, to provide treatment.

Participation in the HIE is voluntary. Your child/ward will be enrolled unless you opt-out. You may opt-out at any time. A decision to opt-out will not have any effect on any benefits to which your child/ward may otherwise be entitled; however, they will not be able to participate in an HIE.

I consent for my child/ward to participate in health information exchange systems. I understand that I must provide written authorization for Peace River Center to request and access my child/ward's health information through the HIE.
___ Yes ___ No

OPT-OUT STATEMENT

I have considered whether to allow my child/ward's health information to be viewed in the health information exchange system(s) in which Peace River Center participates and have decided to OPT-OUT and NOT allow information to be viewed. By choosing to opt-out of the HIE, I acknowledge and agree as follows:

- This opt-out only applies to the sharing of health information through the HIE. Healthcare providers may still have access to my child/ward's health information using other methods such as fax, telephone or mail.
- By opting out of participation in the HIE, my child/ward's healthcare providers outside of Peace River Center will NOT be able to search for my child/ward's Peace River Center Records through the HIE while providing them treatment.
- I understand that if any information has been shared through the HIE before I submit this opt-out form, that information will remain with providers who accessed it before this opt-out went into effect.

This HIE op-out election will remain in effect until I notify Peace River Center and complete a consent to participate in the HIE, which I may do at any time.

## Patient's Rights and Privileges

As a patient of Peace River Center your child/ward has the following rights:

1. The right to respect and dignity at all times.
2. The right to receive quality treatment.
3. The right to impartial access to treatment, regardless of race, sex, handicap, age, or ethnicity.
4. The right to receive individualized treatment, within the least restrictive environment. Treatment will include an individualized treatment plan that will be reviewed at least every 6 months.
5. The right to be provided with the appropriate qualified, competent and experienced professional clinical staff to implement and supervise my child/ward's treatment plan.
6. The right to file a grievance if I feel my child/ward's therapist is not acting on their behalf.
7. The right to be informed by my child/ward's physician or counselor about any proceedings to hold them involuntarily.
8. The right to access to my child/ward's clinical record.
9. The right to be free from neglect; exploitation; and verbal, mental physical or sexual abuse while they are receiving care, treatment, or services.
10. The right to strict confidentiality of all information about my child/ward except under the following exceptions:
    a. Where there is a threat to harm another individual or themselves.
    b. Where there are suspicions or knowledge of abuse (child, elderly, disabled, etc.)
    c. Where there is a court-order for information
    d. Where there is medical emergency.

*I understand that these exceptions are required by law.

*I do hereby acknowledge that I have read my child/ward's rights and privileges as a parent/legal guardian of a patient of Peace River Center and I understand them.
*I understand I have the right to report any violations of my child/ward's patient rights to the toll-free Abuse Registry number listed: **Abuse Registry: 1-800-96-ABUSE**

I understand my child/ward's rights and privileges ___ Yes ___No

## Missed Appointments

All appointments must be canceled 24 hours prior to the appointment date and time. If you do not cancel the appointment, your child/ward may be a walk-in only client.

## Billable Services

All services are billable. The Registrar may not know all the services performed the day of your child/ward's appointment until the clinician or doctor completes the necessary forms and bills for the services. These services will show up on your child/ward's monthly statement and are due upon receipt.

## Financial Agreement

In consideration of the services to be rendered to the client, I individually promise to pay the client's account at the rates stated in Peace River Center's (PRC) price list (known as the 'Charge Master') effective on the date the charge is processed for the service provided, which rates are hereby expressly incorporated by reference as the price term of this agreement to pay the client's account. Some special items will be priced separately if there is not a price listed on the Charge master, or if the charge is listed as zero. An estimate of the anticipated charges for services will be provided to me upon my request from PRC. Estimates may vary significantly from the final charges based on a variety of factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

If supplies and services are provided to my child/ward and I have coverage through a governmental program through certain private health insurance plans, PRC may accept a discounted payment for those supplies and services. In this event, any payment required from me will be determined by the terms of my governmental program or private health insurance plan. If my child/ward is uninsured and not covered by a governmental program, they may be eligible to have their account discounted or forgiven under PRC's self-pay collection policy in effect at the time of treatment. I may request information about this policy from PRC.

As a courtesy to me, PRC may bill my insurance company, but is not obligated to do so. Regardless, I agree that except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I agree to pay any services that are not covered by the insurance company. This includes, but is not limited to coinsurance, deductibles, non-covered benefits due to policy limits or policy exclusions as well as failure to comply with my insurance plan requirements. I also agree that if PRC must initiate collection efforts to recover amounts owed by me, then in addition to amounts incurred for the services rendered I will pay: (a) any and all costs incurred by PRC in pursuing collection, including, but not limited to, reasonable attorneys' fees, and (b) any court costs or other costs of litigation incurred by PRC that applicable rules or statutes permit PRC to recover. I hereby authorize PRC to obtain consumer reports concerning me from one or more consumer reporting agencies. I understand that PRC may obtain consumer reports concerning me without my written authorization under some circumstances as permitted by law.

## Assignment of Benefits

In executing this assignment of benefits, I am directing the health insurance carrier or other health benefit plan providing my child/ward's coverage (including, but not limited to, any employer, employer group or trust sponsored or offered plan) to pay PRC directly for the services PRC provided to the patient during this admission. In return for the services rendered and to be rendered by PRC, I hereby irrevocably assign and transfer to PRC all right, title, and interest in all benefits payable the healthcare rendered, which are provided in any and all insurance policies and health benefit

plans from which my child/ward is entitled services or is entitled to recover. I understand that any payment received from these policies and/or plans will be applied to the amount that I have agreed to pay for services rendered during this admission, as further described in the Financial Agreement section. This assignment shall be for the purpose of granting PRC an independent right of recovery against the insurer or health benefit plan, but shall not be construed as an obligation of PRC to pursue any such right of recovery. In no event will PRC retain benefits in excess of the amount owed to PRC for the care and treatment rendered during the admission. If a third party payer (such as an insurance company , employer group, trust sponsored or offered plan) may be obligated to pay some or all of these charges, I agree to take all actions necessary to assist PRC in collecting payment from any such third party payer. I hereby appoint PRC as my authorized representative to pursue, if it so chooses, all administrative remedies, claims and/or lawsuits on my behalf and at PRC's election, against any responsible third party, medical insurer, or employer sponsored medical benefit plan for the purpose of collecting any and all PRC benefits due me for the payment of the chargers referred to in the Financial agreement section. If PRC elects to pursue a claim or lawsuit against a third party payer as authorized representative, I agree to execute a special power of attorney, if requested, authorizing PRC to take all actions necessary or appropriate in pursuit of such claim or lawsuit, including allowing PRC to bring suit against the third party payer in my name. I agree to pay over to PRC immediately all sums recovered in any claim or lawsuit brought on my behalf by PRC (up to the amount of PRC's charges, plus expenses and attorneys' fees).

I have read and been given the opportunity to ask questions about this assignment of benefits. ___ Yes ___ No

**Is the client participating in SAMHSA funded Grant Project?** ___ Yes ___ No

*If no, please skip this section.*

In signing this Consent for Treatment, I am consenting for my child to participate in the SAMHSA funded service intervention to assist in our engagement and retention in mental health treatment services. This program is funded by a grant with the Substance Abuse and Mental Health Services Administration, and as such, data is collected as part of the program. I consent to this data collection and the provision of data information back to the Substance Abuse and Mental Health Services Administration for the purposes of grant tracking and de-identified result gathering.

I have signed this Document freely and without inducement, other than the rendition of services by PRC.
___ Yes ___ No

_____ _____ _____
Patient Name Date of Birth Social Security Number

_____ _____
Signature of Patient or Guardian Date

_____ _____
Signature of Witness Date

**Inspect and Obtain a Copy:** You have the right to inspect and obtain a copy of the medical information that may be used to make decisions about your care by requesting it in writing and providing us with the specific information we need to fulfill your request. Usually, this includes medical and billing records, but does not include psychotherapy notes or information compiled in reasonable anticipation of civil, criminal or administrative proceedings. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by the Center will review your request and the denial. The person conducting the review will not be the person who participated in the denial of your original request. We will comply with the outcome of the review.

**Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information in writing with a reason to support a request for amendment. You have the right to request an amendment for as long as the information is kept by or for the Center. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

**An Accounting of Disclosures:** You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your medical information for purposes other than treatment, payment or healthcare operations where an authorization was not required.

**Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care. For example, you could ask that we not use or disclose information about a service that you received. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

**Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you at work instead of your home. The Center will grant requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the Center and related correspondence regarding payment for services. Please realize we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

**A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If the Center has a website you may print or view a copy of the notice by clicking on the Notice of Privacy Practices link.

**CHANGES TO THIS NOTICE**

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the Center, and if the Center has a website, to the website. Any revised or changed notice will include the effective date and you may obtain a written copy upon request.

**OTHER USES OF MEDICAL INFORMATION**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you and documented.

If you have any questions about this notice, please contact the Center Privacy Official (the Chief Operating Officer) by dialing 863-519-0575.



# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time you receive a service from Peace River Center (the “Center”), a record of your visit is made. Typically, this record contains your symptoms, assessments and evaluations, diagnoses and treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated at Peace River Center referred to in this Notice as “medical information”.

Effective Date: April 14, 2003
Revised: March, 2024

**OUR RESPONSIBILITIES:**
**We are required by law to maintain the privacy of your medical information and provide you a description of our privacy practices. We will abide by the terms of this notice.**

**USES AND DISCLOSURES:**
**How we may use and disclose Medical Information about you.**
**The following categories describe examples of the way we use and disclose medical information:**

**For Treatment: We may use medical information about you to provide you with treatment or services. We may disclose medical information about you to doctors, nurses, therapists, case managers, or other personnel who are involved in taking care of you at the Center. For example: a doctor at the Crisis Unit may need to know what medications you received in outpatient care. Different programs in the Center may also share medical information about you in order to coordinate the different things you may need, such as prescriptions, case management, lab work, and meals. We may also provide medical information to a Health Information Exchange (HIE) and their partner agencies or another health care provider who we consult about your treatment or who we refer you for treatment. If you do not wish your protected health information to be shared with a health information exchange, please advise the Registration staff to complete the HIE Opt-Out form.**

**For Payment:** We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your diagnosis so it will pay us or reimburse you for treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

**For Health Care Operations:** Members of the treatment staff and/or quality improvement team may use information in your medical record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may also combine medical information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, therapists, caseworkers and students for educational purposes. And we may combine medical information we have with that of other mental health centers to see where we can make improvements. We may remove information that identifies you from this set of medical information to protect your privacy. We may also use and disclose medical information:

- To business associates we have contracted with to perform the agreed upon service and billing for it;
- To remind you that you have an appointment for care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health-related benefits or services;
- To conduct quality assessment and improvement activities for the health care services we provide;
- To undertake business planning and management activities; and
- To conduct training programs or review competence of healthcare professionals.

When disclosing information, primary appointment reminders and billing/collections efforts, we may leave messages on your answering machine or voice mail.

**Business Associates:** There are some services provided in our organization through contracts with business associates. Examples include, but are not limited to, transcriptionists, auditors, and attorneys. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do and bill you, your insurance company, a third-party payer for services rendered, or the Center. To protect your medical information, however, we require the business associate to appropriately safeguard your medical information.

**Individuals Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care only after receiving verbal or written authorization from you. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

**Research:** We may disclose your medical information to researchers when an internal review committee has reviewed and approved the provision of information for the research proposal and established protocols to ensure the privacy of your medical information, or information identifying you has been removed from the medical information. Information that identifies you will be kept confidential.

**As Required By Law:**
We may also use and disclose medical information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Military Command Authorities
- Health Oversight Agencies
- Coroners, Medical Examiners, and Funeral Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- Authority authorized by law to receive reports of Abuse, Neglect, Exploitation or Domestic Violence
- Entities using the medical information to avert a serious threat to health or safety

**Law Enforcement/Legal Proceedings:** We may disclose medical information for law enforcement purposes as required by law or in response to a valid subpoena or a court order.

**Psychotherapy Notes:** Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the type and regularity of treatment furnished, results of clinical test, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Psychotherapy notes may not be disclosed without your written authorization except in certain limited circumstances:

- Use or disclosure in supervised mental health training programs for students, trainees, or practitioners;
- Use or disclosure by the covered entity to defend a legal action or other proceeding brought by the individual;
- A use or disclosure that is required by law;
- A use or disclosure that is permitted:
    - for legal and clinical oversight of the psychotherapist who made the notes,
    - to prevent or lessen a serious and imminent threat to the health or safety of the public

**State Specific Requirements:** Many states have requirements for reporting including population-based activities relating to improving health or reducing healthcare costs. Some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

**COMPLAINTS**
If you believe your privacy rights have been violated, you may file a complaint with the Center by submitting the complaint in writing to: PRC Privacy Officer, P.O. Box 1559, Bartow, FL 33831-1559. You may also file a complaint with the Secretary of the Department of Health and Human Services by sending it to Medical Privacy, Complaint Division Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, SW., Room 509F, HHH Building, Washington D.C. 20201. **You will not be retaliated against for filing a complaint.**

**YOUR MEDICAL INFORMATION RIGHTS**
Although your medical record is the physical property of the Center, you have the **Right to:**

# Credible Client Portal
# Authorization Agreement, Release of Liability and Terms and Conditions of Use

You are requesting access to portions of your minor child's health information, as well as the ability to communicate with Peace River Center ("PRC") providers regarding health information by using an Internet-based electronic application called the Credible Client Portal. In order to obtain access to the Credible Client Portal, you are required to acknowledge that you have read these Terms and Conditions and find them acceptable. PRC reserves the right to make any changes to these Terms and Conditions at any time without notifying you or obtaining your agreement. Any changes to the Terms and Conditions will be posted on the PRC website.

We will communicate with you by e-mail and/or messaging on this site. You agree that all agreements, notices, disclosures and other communications that we provide you electronically satisfy any legal requirements that such communications be in writing. The Client Portal is intended to save you time and ease communications between you and your child's provider(s). It does not allow for any type of diagnosis or mental health advice, and should never be used in an emergency situation. You may contact the appointment line via telephone at any time.

## Privacy

The privacy of your child's health information is extremely important to us. PRC will use and disclose your child's health information in order to provide your child with health care services. PRC will maintain your child's health information in strict confidence and will not disclose it to any unaffiliated third party unless you authorize that person to receive your child's health information or it is permitted to be disclosed by law. Please review PRC's Notice of Privacy Practices for an explanation of how, when, and why we use and disclose your child's health information. All electronic messages sent and received within the Credible Client Portal that contain health information are subject to all state and federal laws governing the security and confidentiality of medical records.

## Use/Access

**The Credible Client Portal should never be used for urgent matters**. For all urgent medical matters, contact the provider's office by phone, and/or go to the emergency department of a local hospital, and/or dial 911.

All information in the Credible Client Portal is provided "as is" without warranty of any kind, and is meant for use only to support your relationship with your minor child's provider. Your reliance on the information provided in the Credible Client Portal is not a replacement for proper medical attention. The information displayed in the Credible Client Portal may not be the complete medical record. Therefore, you must contact PRC directly for official and complete copies of your medical record, or in regard to discrepancies with the medical information listed in your record.

The Credible Client Portal may not be available to you at all times due to system failures, procedures, maintenance, or other causes beyond PRC's control. Access is provided on an "as-is, as available" basis, and PRC does not guarantee that you will be able to access the Credible Client Portal at any particular time.

PRC will make its best effort to provide a timely response to your electronic messages. In some situations, the staff that must respond to a message may not be immediately available.

Your electronic messages may be shared with the PRC staff member that assists your child's provider in providing services to you. Your messages will only be available to designated professionals. If your minor child's provider is out of the office or unavailable, messages sent within the Credible Client Portal may be routed to other appropriate and authorized caregivers within PRC in order to facilitate a timely response to your request.

**Inappropriate Use/Termination**

Credible Client Portal access is granted for the purpose of furthering your minor child's medical care. Use of the Credible Client Portal unrelated to this purpose may result in the suspension or termination of access privileges. Improper use includes, but is not limited to, the use of inappropriate, threatening or abusive language, requesting appointment times that are frequently cancelled, and any other use that PRC determines in its sole discretion constitutes a disruption to PRC operations. PRC reserves the right, in its sole discretion, to terminate a user's access to all or part of the Credible Client Portal website, with or without notice.

**Credible Client Portal ID and Password**

You will be provided with an access code when you initially enroll in the Credible Client Portal. The login name and password you choose will be used to access your child's health information in the Credible Client Portal and are unique codes that identify you in the Credible Client Portal system. Any inquiries and entries you make in the Credible Client Portal will be logged with your identity and may become part of your minor child's official medical record. Therefore, it is extremely important that you keep your login name and password completely confidential. Anyone with access to your login name and password will be able to access your child's health information, as well as read your messages and send new message as if they were you. It is your responsibility to prevent disclosure of your login name and password, and to change your password if you feel that the security of your password has been compromised. You may change your password at any time by contacting the Health Information Services/Medical Records Department.

**Verification of Identity**

Your enrollment in the Credible Client Portal is contingent on verification of your identity by a PRC employee. You may access the Peace River Center Credible Client Portal through our website at: www.peacerivercenter.org.

**Secure Communications**

All communication between you and PRC providers occur over a secure connection. However, if you elect to receive Internet e-mail messaging notifying you that new information is available in your Credible Client Portal account, please take the following into consideration. Although these e-mail messages will not contain your medical information, the notification that new medical information is available by accessing the Credible Client Portal may be information that you do not want others to know. Therefore, you should take this into account when providing PRC with your e-mail address. All of the health information available to you is accessed within your Credible Client Portal account and is protected and securely maintained by PRC. Although the Credible Client Portal is configured to be secure from unauthorized access, PRC is not responsible for:

- Absolute security of all electronic communication transmissions between the client and PRC;
- Unauthorized disclosure resulting from a user not logging out of an active session;

- Unauthorized disclosure resulting from a lost, stolen, or shared login name and/or password;
- Unauthorized disclosure resulting from information printed from the Credible Client Portal by the user;
- Unauthorized disclosure resulting from personal computer settings or installed software products that may compromise information security; or
- Similar events beyond the substantial control of PRC.

Our personnel will never ask you for your password in an unsolicited phone call or in an unsolicited e-mail. Remember to sign out of your account and close your browser window when you have finished your session to help ensure that others cannot access your personal information.

If you are not receiving email notifications that you have a message in the Client Portal, please check your email account settings. Spam blocking software may be blocking legitimate emails from Peace River Center Credible Client Portal. To receive emails, please add credibleportal.com to your contact list, address list, and/or "Do Not Block" list.

For ease of use and to maintain security of your personal health information, the following guidelines should be followed:

- Advise us of any changes in you primary contact email address
- Use caution when communicating highly sensitive or personal information via the Peace River Center Credible Client Portal
- Always follow up with the appointment line if an inquiry/message through Peace River Center Credible Client Portal is not responded to within 3 business days.
- Do not store messages on any device or computer not personally owned.
- Never use the Client Portal for emergency needs.

**Property Rights**

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Users are prohibited from posting or transmitting any unlawful, threatening, libelous, defamatory, obscene, scandalous, inflammatory, pornographic or profane material on the Credible Client Portal website. If something a user posted or transmitted results in or encourages conduct that is considered a criminal offense, civil liability or otherwise violates any law, the website owner will fully cooperate with law enforcement authorities or court order requesting or directing the website owner to disclose the identity of anyone posting such information or materials.

**Choice of Law and Forum**

The terms and conditions set forth above shall be governed by and construed in accordance with the laws of the State of Florida. All users expressly agree that the exclusive jurisdiction of any claim or action arising out of or relating to these terms and conditions or any use of this website shall be filed only in the state or federal courts located in the State of Florida. Further, all users agree and submit to the exercise of personal jurisdiction of such courts for the purpose of litigating any such claim or action.

**Severability and Integration**

Unless otherwise specified herein, the terms and conditions stated above constitute the entire agreement between the user and PRC with respect to this website and supersedes all prior or contemporaneous communications and proposals (whether oral, written, or electronic) between the user and PRC with respect to this website. If any part of the terms and conditions is held invalid or unenforceable, that portion shall be construed in a manner consistent with applicable law to reflect, as nearly as possible, the original intentions of the parties, and the remaining portions shall remain in full force and effect.

**Alternative User Authorization**

If you would like a family member or another type of user to have access to your electronic medical records using the Credible Client Portal, please contact the Health Information Services/Medical Records Department to complete the Alternative User Authorization form.

# Credible Client Portal
# Minor Child Authorization Agreement,
# Requirements and Procedures for accessing the Electronic Medical Record of Children < 18 years of age

**Requirements for accessing a child's record:**

- The individual(s) requesting access must have parental or legal guardianship rights (legal documentation will be required).
- The Minor Child Authorization Agreement, included below, must be completed. Two parents or guardians may apply for access on one application, but a separate application is required for each child. A signature from each parent/guardian listed on the application is required unless both parents/guardians live at the same address.
- Each parent/guardian requesting access must establish their own Credible Client Portal login in order to access the child's record.
- Acknowledge Credible Client Portal is not to be used in an emergency.
- Agree to abide by the terms and conditions of the Credible Client Portal site.

**Procedures for parents/guardians accessing a child's record:**

- Once the authorization form is completed, parental/guardian access to the child's record will be established within 2 business days.

**Parent/Guardian access to a child's record shall be revoked when:**

- Parent/Guardian submits a request the child revoke the access online.
- Child turns 18 years old.
- Child advises Health Information Management of his/her emancipated status.
- Parent/parent or parent/child access disputes cannot be resolved.
- PRC reserves the right to revoke access to Credible Client Portal at any time for any reason.

# Credible Client Portal
# Minor Child Authorization Agreement, Requirements and Procedures for accessing the Electronic Medical Record of Children < 18 years of age

**Please print Parent/Legal Guardian information** (A separate form is required for each child)**:**

First Name of Parent/Legal Guardian

Last Name of Parent/Legal Guardian

Date of Birth

Email Address

Complete Mailing Address

Telephone Number(s)

Relationship to Client

**If applicable, please print second Parent/Legal Guardian information:**

First Name of Parent/Legal Guardian

Last Name of Parent/Legal Guardian

Date of Birth

Email Address

Complete Mailing Address

Telephone Number(s)

Relationship to Client

# Credible Client Portal
# Minor Child Authorization Agreement,
# Requirements and Procedures for accessing the Electronic Medical Record of Children < 18 years of age

I have read and understand the requirements and procedures for accessing my child's/client's medical record information online as provided on page one of this document. I certify that I am the parent or legal guardian of the child listed below and that all information provided is correct. If I am not the parent but a legal guardian, I have provided the required documentation. I hereby request access to my child's/this client's electronic medical record. I understand that this electronic access will end upon my child's/the client's 18th birthday.

I understand that this access will be in effect until such time that I notify PRC via a written letter, to the address provided below, to terminate access. Access to the Credible Client Portal may be terminated at any time.

I agree that I am responsible for the security and privacy of my username and password, as well as the information I obtain, copy, or print from Peace River Center Credible Client Portal. I understand that information released to me is no longer protected by state and federal privacy laws.

| | |
|---|---|
| Child's Full Name | Date of Birth |
| Parent/Legal Guardian Signature | Date |
| Parent/Legal Guardian Signature (if applicable) | Date |
| Parent/Legal Guardian Email Address | Date |

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**Please bring the following information to your appointment**

1. Proof of residence (Driver's license or photo ID, Bill, Lease Agreement)
2. Proof of Income
3. Insurance Cards
4. Social Security Card
5. Authorization if required

********If client is a minor, they must be accompanied by the **LEGAL GUARDIAN** *****

Please call if you are unable to keep scheduled appointment. If you need immediate intervention, please call the CRISIS LINE at 863-519-3744.

**Proof of Income accepted:**

1. Income Tax Return
2. Proof of Medicaid Denial
3. Statement of Earnings (see office information below)
4. Paystubs (2)
5. Unemployment Statement
6. Food Stamp Letter

I understand that I am required to bring in the above information to the Intake appointment. I understand that if I fail to provide this information I may not be scheduled with the medical department.

*Statement of earnings may be requested from the Social Security office:

Social Security
550 Commerce Dr
Lakeland FL 33813
1-800-772-1213

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PRC Staff Only:

Annual Income: _____

# in Household: _____

SAMH % _____

## Proof of Income

Client Name: _____ Client ID#: _____

Did the Parent/Guardian provide proof of income? ____ Yes (Please attach.) ____ No

Did the Parent/Guardian provide verbal income information? ____ Yes ____ No

If yes, how much income monthly? _____ How many in the household? _____

Source of income (employment, unemployment, SSI)? _____

Did Parent/Guardian state they will provide POI at next appointment? ____ Yes ____ No

If no, please explain reason: _____

_____

_____

Did Parent/Guardian provide Proof of Address? ____ Yes (Please attach.) ____ No

Did Parent/Guardian state they will provide Proof of Address at next appointment? ____ Yes. ____ No

If so, please explain reason: _____

_____

_____

By signing below, you are verifying that the information provided is accurate to the best of your knowledge. If you did not provide Proof of Income and/or Proof of Address, it is your responsibility to bring this with you to your next scheduled appointment.

_____ _____

Parent/Guardian Signature Date

_____ _____

PRC Staff Signature Date

**By signing below, you are verifying that the information provided is accurate to the best of your knowledge. If you did not provide Proof of Income and/or Proof of Address, it is your responsibility to bring this with you to your next scheduled appointment.**

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PRC Staff Only
Client ID: _____

**Billing Information:**

Name of Individual Receiving Services at Peace River Center: _____

Relationship: ☐ Self ☐ Spouse or ☐ Dependent or Child

**Insurance Information:**
Is insurance being used today? ☐ Yes. Please complete the information below. ☐ No. Please skip to Section 2.

Name of Individual with Insurance Coverage and Responsible for Additional Fees (Co-pay, etc.):

Full Name: _____

Insurance: _____

Insurance ID: _____ Insurance Dates: _____

Insurance Last Updated: _____ Co-Pay: _____

Section 2

**Individual Responsible for Payment:**

Name of Individual Responsible for Payment of Services: _____

Please provide the billing address and additional information for the primary insurance holder or individual responsible for payment. If coverage is for a child or dependent, please indicate the parent/guardian responsible for payment.

Billing Address: _____

Billing City: _____ Billing State: _____ Billing Zip: _____

Employment Status of Individual Responsible for Payment? ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled

Occupation: _____

Monthly Income:_____ Number of Dependents: _____

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# Zero Income

Client Name: _____ Client DOB: _____ Client ID: _____

**Choose One:**

- o Client has no proof of income.
- o Currently, I have no income of any kind and, while I am actively seeking employment, there is no definitive job offer at this time.
- o Currently, I have no income of any kind and will not be seeking employment at this time.

**Household Information:** Enter information on all members residing in your household.

| Name | Relationship to Client | Date of Birth | Income |
|---|---|---|---|
| | SELF | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

The following sources of funds pay for Client's basic necessities including: food, shelter, clothing, transportation, and medical care. (Please list name(s) and phone number(s) of person/organization providing basic needs.)

_____

_____

_____

_____

_____

_____

_____

I certify that the information provided in this form is accurate and true.

Signature of Client: _____ Date: _____

**Mental Health Advance Directive Refusal**

This Advance directive was reviewed with me and I have chosen to decline having an Advance directive.

Printed Name (Declarant): _____

Signature: _____ Date: _____

This advance directive was signed by _____ in our presence. At his/her request, we have signed our names below as witness. We declare that, at the time this advance directive was signed,

Dated at _____, this _____day of _____,

(County & State) (Day) (Month)

_____.

(Year)

Witness Signatures:

Witness 1:

_____ _____

Printed name of Witness 1 Signature of Witness 1

Witness 2:

_____ _____

Printed name of Witness 2 Signature of Witness 2

**Advance Care Planning: Healthcare Directives**

Advance care planning is not just about old age. At any age, a medical crisis could leave you too ill to make your own healthcare decisions. Even if you are not sick now, planning for health care in the future is an important step toward making sure you get the medical care you would want, if you are unable to speak for yourself and doctors and family members are making the decisions for you.

Many Americans face questions about medical treatment but may not be capable of making those decisions, for example, in an emergency or at the end of life. This article will explain the types of decisions that may need to be made in such cases and questions you can think about now so you're prepared later. It can help you think about who you would want to make decisions for you if you can't make them yourself. It will also discuss ways you can share your wishes with others. Knowing who you want to make decisions on your behalf and how you would decide might take some of the burden off family and friends.

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Phone:888-300-7410
FAX: 863-499-2528

# Authorization for Release or Exchange of Confidential Information

**Patient/Client:** **Clinical Record:** **DOB:**

This form authorizes Peace River Center, to release or exchange information as indicated below, regarding the client's contacts/ treatments in accordance with Florida Statutes and Federal Administrative Rules and Regulations to/from:

**I hereby Authorize (Name):**_____

**Street Address:**_____

**City:**_____ State:_____ **Zip:**_____

**Phone:**_____ **Fax:**_____

**I also authorize the following entities as indicated by a check mark:**

- ☐ Social Security Administration: 800-325-0778
- ☐ Lakeland Regional Health:863-687-1100
- ☐ Department of Children & Families: 863-534-7100
- ☐ Lakeside Pediatrics:863-688-3550
- ☐ Health Information Exchange (HIE) and HIE Partner Agencies

**Purpose of Disclosure:** ☐ Legal ☐ Disability ☐ Continuity of Care ☐ Self Other:_____

**Information may be Received as follows:**

☐ Psychiatric/Psychological ☐ Substance/Alcohol Abuse ☐ Medical/Hospital Information
☐ HIV/AIDS ☐ Verbal Communications ☐ None Other:_____

**Information may be Released as follows:**

☐ Psychiatric/Psychological ☐ Substance/Alcohol Abuse ☐ Medical/Hospital Information
☐ HIV/AIDS ☐ Verbal Communications ☐ None Other:_____

**Costs of Reproducing Medical Records**: PRC reserves the right to charge a reasonable cost for reproducing records, set forth by Florida Administrative Code 64B8-10.003. By signing this Release of Information form, I understand that I may be responsible for any costs incurred.

**Notice of Prohibition on Re-disclosure**: This information has been disclosed to you from records protected by Federal Rules governing confidentiality rules (42 CFR Part 2) and Florida Statutes (394.459, 396.112, 397.053, 381.609, 455.2416, 90.503, 90.242, and 45 CFR Part 160-164). The Federal Rules and State Statutes prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains.

Information used or disclosed pursuant to this authorization may be subject to Re-disclosure by the recipient and no longer be protected by the rules above. Peace River Center is released from all legal liability that may arise from the release of information requested. I understand I have the right to refuse this authorization or revoke it at a later date by submitting a written notice to the address above. I understand that I am not required to sign this authorization in order to receive treatment. When exchanging information where the patient/client is involved in treatment with other agencies/professionals to assist in coordinating treatment, this authorization may include verbal, written and/or electronic communication.

## This authorization is valid for 5 years unless otherwise specified:

Please answer the following questions if release or exchange of information is sought by the parent/legal guardian of a minor only:

1. Has patient/client been emancipated? Yes No
2. Has patient/client ever been convicted of a crime as an adult? Yes No
3. If the answer to question 2 is yes, is patient/client in the custody or under the supervision of the State Dept. of Corrections? Yes No
4. Has the patient/client ever been removed from your legal custody? Yes No

**If the answer to any question is yes, do not release. Contact Health Information Services for guidance.**

**Patient/Client-signature:** **Witness:** **Parent/Guardian Signature:**

**Print-Parent/Guardian Name:**

**Date:**

**Relation to Patient/Client:**

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Phone:888-300-7410
FAX: 863-499-2528

# Authorization for Release or Exchange of Confidential Information

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**I hereby Authorize (Name):**_____

**Street Address:**_____

**City:**_____ State:_____ **Zip:**_____

**Phone:**_____ **Fax:**_____

**I also authorize the following entities as indicated by a check mark:**

- ☐ Social Security Administration: 800-325-0778
- ☐ Lakeland Regional Health:863-687-1100
- ☐ Department of Children & Families: 863-534-7100
- ☐ Lakeside Pediatrics:863-688-3550
- ☐ Health Information Exchange (HIE) and HIE Partner Agencies

**Purpose of Disclosure:** ☐ Legal ☐ Disability ☐ Continuity of Care ☐ Self Other:_____

**Information may be Received as follows:**

☐ Psychiatric/Psychological ☐ Substance/Alcohol Abuse ☐ Medical/Hospital Information
☐ HIV/AIDS ☐ Verbal Communications ☐ None Other:_____

**Information may be Released as follows:**

☐ Psychiatric/Psychological ☐ Substance/Alcohol Abuse ☐ Medical/Hospital Information
☐ HIV/AIDS ☐ Verbal Communications ☐ None Other:_____

**Costs of Reproducing Medical Records**: PRC reserves the right to charge a reasonable cost for reproducing records, set forth by Florida Administrative Code 64B8-10.003. By signing this Release of Information form, I understand that I may be responsible for any costs incurred.

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Information used or disclosed pursuant to this authorization may be subject to Re-disclosure by the recipient and no longer be protected by the rules above. Peace River Center is released from all legal liability that may arise from the release of information requested. I understand I have the right to refuse this authorization or revoke it at a later date by submitting a written notice to the address above. I understand that I am not required to sign this authorization in order to receive treatment. When exchanging information where the patient/client is involved in treatment with other agencies/professionals to assist in coordinating treatment, this authorization may include verbal, written and/or electronic communication.

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1. Has patient/client been emancipated? Yes No
2. Has patient/client ever been convicted of a crime as an adult? Yes No
3. If the answer to question 2 is yes, is patient/client in the custody or under the supervision of the State Dept. of Corrections? Yes No
4. Has the patient/client ever been removed from your legal custody? Yes No

**If the answer to any question is yes, do not release. Contact Health Information Services for guidance.**

**Patient/Client-signature:** **Witness:** **Parent/Guardian Signature:**

**Print-Parent/Guardian Name:**

**Date:**

**Relation to Patient/Client:**

# NATIONAL VOTER REGISTRATION ACT
## Preference Form/Application

**Client's preference (check the box only in 1. or 2.)**

*If you do not check any box, it will be considered that you chose not to register or update your voter registration at this time.*

**1. If you are not registered to vote where you live now, would you like to apply to register to vote today?**

☐ Yes ☐ No, I decline.

**2. If you are registered to vote where you live now, would you like to update your voter registration record?**

☐ Yes ☐ No, I decline.

**CLIENT:** _____
Name or identification number Date

**OFFICIAL USE ONLY** (check all that apply)

[Note: Only a client who is eligible can decline or accept an opportunity to register or update a record on his or her behalf]

1. **Client applied for:** ☐ New services/assistance ☐ Renewal of services/assistance ☐ Address change
2. **How client applied:** ☐ In person ☐ By phone ☐ At home ☐ Online/web service
3. **Client:** ☐ Submitted registration application. ☐ Was sent form/application on ___/___/___(date). ☐ Did not complete application/took form/application.

Preference form must be retained by agency for two years from dated form (DS-DE 77-ENG; rev. 11-2011)

## ==========Notice of Rights==========

**Help:** If you would like help in filling out your voter registration application, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration application in private.

**Benefits:** If you are applying for public assistance from this agency, applying to register, or declining to register to vote will not affect the amount of assistance you will be provided by this agency.

**Privacy:** Your decision not to register or update your record and the location where you applied to register or update your voter registration record is confidential and may only be used for voter registration purposes.

**Formal Complaint:** If you believe someone has interfered with either your right to apply to register or to decline to register to vote, your right to privacy in deciding whether to apply to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Florida Secretary of State, Division of Elections, NVRA Administrator, R.A. Gray Building, 500 S. Bronough Street, Tallahassee, Florida 32399-0250. Forms for filing a complaint are available at http://election.dos.state.fl.us/nvra/index.shtml or call 1-850-245-6200.

[Authority: National Voter Registration Act (42 U.S.C. 1973gg); sections 97.023, 97.058, and 97.0585, F.S.]

## To Register to Vote in Florida, You Must:

- Be a U.S. citizen (a lawful permanent resident cannot register or vote)
- Be at least 18 years old (you may pre-register if you are at least 16 years old although you cannot vote until you are 18 years old)
- Be a Florida resident
- Have had your right to vote restored if you have ever been convicted of a felony
- Have had your right to vote restored if a court has ever declared you to be mentally incapacitated as to your right to vote.

**If you do not meet these requirements, you are not eligible to register.**

---

## You Can Register to Vote at:

- Any Supervisor of Elections' office
- Any driver's license office or tax collector's office that issues driver's licenses
- Any voter registration agency (that is, any public assistance office, any office that provides services for persons with disabilities, any center for independent living, any armed forces recruitment office or any public library)
- The Division of Elections (Florida Department of State)

---

## You Can Hand-in or Mail a Completed Application to Any of the Locations Listed Above

**I**f mailing, mail with sufficient postage to:

Division of Elections
***R.A. Gray Building***
***500 S. Bronough Street***
***Tallahassee, Florida 32399-0250***

***(contact information: 850-245-6200; http://election.dos.state.fl.us)***

Your Supervisor of Elections will contact you if your application is incomplete, denied, or a duplicate. Once you are registered, you will receive a voter information card.

**********Turn Page Over for Registration Application**********

# Application to Register in Florida

## Part 1 - Instructions

**To Register in Florida, you must:** Be a U.S. citizen, be a Florida resident and at least 18 years old (you may also pre-register if you are 16 or 17 years old but you cannot vote until you are 18).

If you have ever been convicted of a felony or if a court has ever found you to be mentally incapacitated as to your right to vote, your right to vote has to be restored before you can register.

***If you do not meet any <u>one</u> of these requirements, you are not eligible to register.***

**Where to Register:** You can register to vote in-person or by mailing or hand-delivering your application to any supervisor of elections' office, any office that issues driver's licenses, any voter registration agency (for example, any public assistance office, assisted living facility, office serving persons with disabilities, public library, or armed forces recruitment office) or the Division of Elections. *If mailing application, be sure to add sufficient postage.*

**Deadline to Register:** The deadline to register to vote is 29 days before an upcoming election. You can update your registration record at any time, but to change your political party for a primary election, you must make the change by the registration deadline. For a new application, you will be contacted if your application is incomplete, denied or a duplicate of an existing registration. If you receive a voter information card, that means you are registered to vote.

**Identification (ID) Requirements:** If you are a new applicant, state and federal law require you to provide a current and valid Florida driver's license number (FL DL#) or Florida identification card number (FL ID#). If you have not been issued a FL DL# or FL ID#, you must then provide the last four digits of your Social Security Number (SSN). If you have not been issued any of these ID numbers, check "None" on the application. If you do not provide any number or do not check "None," your registration may be denied. See s.303, HAVA and section 97.053(6), Fla. Stat.

***Special ID requirements:*** If you are registering by mail, have never voted in Florida, <u>and</u> have never been issued one of the ID numbers above, you must include with your application, or at a later time before you vote, one of the following:

- A copy of an ID that shows your name and photo *(acceptable IDs)*--U.S. Passport, debit or credit card, military ID, student ID, retirement center ID, neighborhood association ID, or public assistance ID; **or**
- A copy of an ID that shows your name and current residence address *(acceptable documents)*--utility bill, bank statement, government check, paycheck, or other government document.

You do not have to provide the special ID to register if you are 65 or older, have a temporary or permanent physical disability, are a member of the active uniformed services or merchant marine who is absent from the county for active duty, or a family member thereof, or are currently living outside the U.S. but eligible to vote in Florida.

**Political Party Affiliation:** Florida is a closed primary election state. That means voters registered with a political party can only vote for that party's candidates in a partisan race on a primary election ballot. However, regardless of the political party with which you registered, you can still vote in the primary election on any issue, any nonpartisan race or any race where the candidate will face no opposition in the general election.

Indicate the political party with which you wish to be registered. If you leave the political party affiliation box blank or write "None," you will be registered without any party affiliation. For a list of political parties registered in Florida, go to the Division of Elections' website under the heading *For the Voters* at: http://election.dos.state.fl.us/

**Race/Ethnicity:** You are not required to list your race or ethnicity. However, if you choose to do so, please choose only one of the following: American Indian/Alaskan Native, Asian/Pacific Islander, Black (Not Hispanic) Hispanic, Multi-racial, White (Not Hispanic), or Other.

**Public Record Notice:** This application becomes a public record when filed. However, the following information is not available to the public and is used only for voter registration purposes: your FL DL#, FL ID# and SSN, where you registered to vote, and whether you declined to register or update your voter registration record when asked by a voter registration agency. Your signature can be viewed but not copied. (Section 97.0585, Fla. Stat.)

**Criminal Offense:** It is a 3rd degree felony to submit false information. Penalties include fines up to $5,000 and/or up to 5 years of prison.

**Questions:** For more information, contact your local supervisor of elections, or refer to the Division of Elections' website at: http://election.dos.state.fl.us..

**Información en español:** Sirvase llamar a la oficina del supervisor de elecciones de su condado si le interesa obtener este formulario en español.

# Application To Register in Florida

## Part 2 - Form (national mail-in application)

Are you a citizen of the United States of America? ☐ Yes ☐ No

Will you be 18 years old on or before election day? ☐ Yes ☐ No

**If you checked "No" in response to either of these questions, do not complete form.**

(Please see state-specific instructions for rules regarding eligibility to register prior to age 18.)

This space for office use only.

| | | | | | |
|---|---|---|---|---|---|
| 1 | | Last Name | First Name | Middle Name(s) | |
| 2 | Home Address | | Apt. or Lot # | City/Town | State / Zip Code |
| 3 | Address Where You Get Your Mail If Different From Above | | | City/Town | State / Zip Code |
| 4 | Date of Birth (Month Day Year) | 5 | Telephone Number (optional) | 6 | ID Number - (See item 6 in the instructions for your state) |
| 7 | Choice of Party (see item 7 in the instructions for your State) | 8 | Race or Ethnic Group (see item 8 in the instructions for your State) | | |

**9** I have reviewed my state's instructions and I swear/affirm that:

- I am a United States citizen
- I meet the eligibility requirements of my state and subscribe to any oath required.
- The information I have provided is true to the best of my knowledge under penalty of perjury. If I have provided false information, I may be fined, imprisoned, or (if not a U.S. citizen) deported from or refused entry to the United States.

Please sign full name (or put mark) ➤

Date: ____ / ____ / ____ (Month / Day / Year)

If this application is for a **change of name,** what was your name before you changed it?

| | | | | |
|---|---|---|---|---|
| A | Last Name | First Name | Middle Name(s) | |

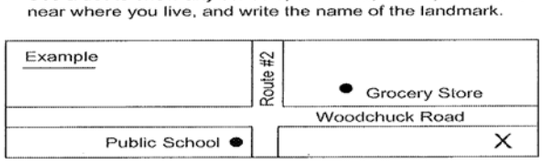
If you were **registered before but this is the first time you are registering from the address in Box 2**, what was your address where you were registered before?

| | | | | | |
|---|---|---|---|---|---|
| B | Street (or route and box number) | Apt. or Lot # | City/Town/County | State | Zip Code |

If you live in a rural area but do not have a street number, or if you have no address, please show on the map where you live.

**C**

- Write in the names of the crossroads (or streets) nearest to where you live.
- Draw an **X** to show where you live.
- Use a dot to show any schools, churches, stores, or other landmarks near where you live, and write the name of the landmark.




NORTH ➤

If the applicant is unable to sign, who helped the applicant fill out this application? Give name, address and phone number (phone number optional).

**D**