HELP-US HELP-U, INC. *d/b/a UNIFY Health & Wellness*

FORM 1 REGISTRATION AND CONSENT

Universal. Type or write the patient's name once; it identifies every other form in this package. If a question does not apply, or the patient does not have the information, write NA. Nothing on this page is required to be seen before care is given.

Patient name	Date of birth

Client ID	Date	Staff

Preferred name	Pronouns	Age

How did you hear about us

HOW WE REACH YOU

Phone	Alternate phone	Email

Where we can usually find you	Best time

☐ OK to leave a message ☐ Text OK ☐ Call only ☐ In person only

A street address is not required. If the patient has no fixed address, record where staff can usually find them.

Emergency contact 1	Relationship	Phone

Emergency contact 2	Relationship	Phone

WHO MAY WE DISCUSS YOUR CARE WITH

This is for everyday logistics only, confirming an appointment, coordinating a ride, checking a balance. It does not authorize release of records to anyone outside HUHU; that requires Form 2.

Name	Relationship	Phone

Name	Relationship	Phone

☐ Everything about my care ☐ Logistics only (appointments, billing) ☐ No one

ABOUT YOU

Language	County	Country of birth

☐ I would like an interpreter

Sex at birth	Gender identity	Sexual orientation
Marital status	**Race**	**Ethnicity**

☐ Pregnant ☐ Not pregnant ☐ Not applicable

WHERE YOU SLEEP

☐ Street or outside ☐ Shelter ☐ With someone ☐ Recovery housing ☐ Own place ☐ Other

If recovery housing, name	How long in this situation
Primary care or last treating provider	**Phone**
Pharmacy you use now	**Phone**

PAYING FOR CARE

☐ None ☐ Medicaid ☐ Medicare ☐ Private ☐ VA ☐ ADAP ☐ Ryan White

Insurance and member ID	Second insurance and ID	
Dental insurance and ID	**Annual family income**	**Family size**

Nobody is refused care because they cannot pay. If a patient has no proof of income today, accept their own statement of it. Photo identification and proof of address are never required.

FORM 1 REGISTRATION AND CONSENT (continued)

READ AND INITIAL. A PATIENT MAY ACCEPT SOME ITEMS AND DECLINE OTHERS.

Initial: _____	**Care.** I agree to receive services here. That may include medical visits in person or by telehealth, medical history and examination, laboratory and sexually transmitted infection testing, medication, minor procedures, behavioral health counseling for individuals or groups, and dental care including history, examination, x-rays, treatment, and medication.
Initial: _____	**Testing.** I agree to HIV, hepatitis, and sexually transmitted infection testing under Florida Statutes 381.004 and 384.25. It is voluntary, I can refuse, results are confidential, and a confirmed positive result is reported to the Florida Department of Health as the law requires.
Initial: _____	**Use of my information.** I agree that my health information, including medical, dental, HIV, sexually transmitted infection, tuberculosis, psychiatric, substance use, and case management information, may be used and shared for my treatment, for payment, and for running and improving the service, and exchanged with the Department of Health, providers, laboratories, pharmacies, and insurers for my care.
Initial: _____	**Substance use records.** If I receive substance use treatment, those records are protected by a stricter federal rule (42 CFR Part 2) and are not shared without my separate written consent, except in a medical emergency, under a valid court order, or where that rule allows. SAMHSA helpline 1-800-662-4357.
Initial: _____	**Privacy notice.** I have received the Notice of Privacy Practices, which explains how my information is used and my rights over it. I know I can ask the Privacy Officer any question or make a complaint.
Initial: _____	**Insurance and benefits.** I assign to this organization the benefits payable under any health plan for services it provides, up to the approved charges, and authorize it to bill my plan. If I have Medicare, I certify the information I give for payment is correct and authorize release of medical information needed for a Medicare claim. I am responsible for charges my plan does not cover, subject to any discount I qualify for.
Initial: _____	**Rights and reporting.** I have been given the Florida Patient Bill of Rights and the grievance procedure. Staff must report suspected abuse, neglect, or exploitation to the Florida Abuse Hotline at 1-800-962-2873 regardless of what else is confidential.

HOW WE MAY CONTACT YOU (CHANGE THIS AT ANY TIME)

☐ Voice message at the phone above ☐ Text message ☐ Email ☐ No messages, contact in person only

☐ I do NOT want voice messages ☐ I do NOT want texts ☐ I do NOT want email

Texts and emails become part of the medical record. HUHU sends the minimum information needed and never states the reason for contact unless the patient asks.

PHARMACY, PATIENT'S CHOICE

HUHU has a pharmacy that can supply medication at reduced cost and coordinate closely with the care team. Use of it is never required, and a patient may fill prescriptions anywhere. This choice does not affect care, eligibility, or any assistance HUHU provides.

☐ Use the HUHU pharmacy ☐ Use another pharmacy ☐ Decide later

OPTIONAL

☐ Telehealth by video or phone ☐ Photographs for education or fundraising
☐ Help applying for Medicaid, ADAP, or Ryan White ☐ Patient portal access

Photographs that identify the patient for marketing require a separate written authorization. Checking this box does not provide that.

QUICK CHECK-IN (PHQ-2)

Over the past two weeks, how often has the patient been bothered by:

1. Little interest or pleasure in doing things (0 / 1 / 2 / 3)
2. Feeling down, depressed, or hopeless (0 / 1 / 2 / 3)

☐ Any thoughts of being better off dead, or of self-harm: NO ☐ YES

IF YES: stay with the patient. Ask whether they mean right now. If yes or unsure, call 988 or 911. If no, refer to behavioral health and arrange follow-up. A score of 3 or more on the two PHQ-2 items is a positive screen; complete the full PHQ-9 before the visit ends.

I confirm the information above is true and complete to the best of my knowledge.

Patient signature	**Date**	
Printed name	**Guardian, if any**	**Staff**