BRANDON RIVERVIEW
MEDICAL ASSOCIATES

REGISTRATION FORM

Today's date:			New patient? (*Please circle*) Yes No		
PATIENT INFORMATION					
Patient's last name: First: Middle:			❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status (Please Choose) Select	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Preferred Name):	Birth date:	Age:	Gender: ◉ M ○ F
Street address:		Social Security no.:	Home phone no.: ( )		
P.O. box:	City:	State:	ZIP Code:		
Occupation:	Employer & Phone No.:	Email:			
Pharmacy Name:	Pharmacy Address:	Pharmacy Phone no: ( )			
Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital		
❑ Family	❑ Friend	❑ Close to home/work	❑ Online	❑ Other:	
INSURANCE INFORMATION					
(*Please give your insurance card to the receptionist*)					
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )		
Is this person a patient here?	❑ Yes ❑ No				
Occupation:	Employer:	Employer address:	Employer phone no.: ( )		
Is this patient covered by insurance?	❑ Yes ❑ No				
Please indicate primary insurance	❑ Humana	❑ Optimum	❑ Freedom	❑ BCBS	❑ Medicare
❑ United Health	❑ Cigna	❑ AETNA	❑ Other:	❑ Other:	
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	Child	❑ Other	

The above information is true to the best of my knowledge. I acknowledge that I will call if there are any changes to my demographic information.

Patient/Guardian Signature: _____ *Date:* _____

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HIPAA CONTACT DISCLOSURE

I,_____ (DOB)_____, give Dr._____
and staff, authorization to disclose my protected health information to the following family, friends and/or caregivers:

Name:_____Relationship:_____Phone:_____
Name:_____Relationship:_____Phone:_____
Name:_____Relationship:_____Phone:_____
Name:_____Relationship:_____Phone:_____

In the event Brandon Riverview Medical Associates may need to give your results or medical information, may we……(check all that apply)

____ Leave a detailed voice message on this phone, the number is _____.
____ Call you on your cellular phone, the number is_____
____ Call you at work, the number is_____
____ Speak to you directly. **ONLY**

Disclaimer: Certain Sensitive health information (treatment / testing) are specifically protected and will not be disclosed outside of the clinic setting without specific authorization. This includes the following:

- Mental / behavioral Health records
- Alcohol / drug dependency treatment
- HIV testing results / AIDS treatment
- Sexually transmitted disease (STD)
- Genetic testing / test results

Please indicate if you allow or deny Brandon Riverview Medical Associates the ability to share this information with you, per the indicated communication option above.

I **allow** Brandon Riverview Medical Associates to share sensitive health information as noted per above options checked on this form. _____ (Patient Signature)

I **DO NOT allow** Brandon Riverview Medical Associates to share sensitive health information as noted above.
_____ (Patient Signature)

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Medical Records department.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment, payment or healthcare operations as sighted in the Notice of Privacy Practices.

I understand that authorizing the disclosure of this health information is voluntary. BRMA, LLC and its entities will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy Practices, which I obtained from my doctor's office.
Unless, otherwise revoked, this authorization will expire on the following date, event or condition:

_____

If I fail to specify a date this authorization will expire one (1) year from the signature on this form.

_____Date_____
Signature of Patient

_____Date_____
Signature of Guardian or Personal Representative

_____Date_____
Signature of BRMA, LLC Employee

Revised 01/2018

BRANDON RIVERVIEW
MEDICAL ASSOCIATES

MEDICAL HISTORY

Patient Name:_____ **DOB:** _____**Date:** _____

(Signs and Symptoms)

MEDICATIONS: _____

ALLERGIES (Includes drugs, food, insects,etc)_____
(Allergy name / Reactions if available)

SURGERY AND PROCEDURES: _____
(Procedure/Year if available)

_____

CONDITIONS AND MEDICAL HISTORY: *Have you had any of the following conditions in the past? Please check all that apply and explain.*

- ❑ Abnormal weight gain/loss _____
- ❑ Alzheimer's Disease/Dementia/Memory Loss_____
- ❑ Dizziness/Numbness/Weakness _____
- ❑ Epilepsy/Seizures _____
- ❑ Fainting/Light-headedness_____
- ❑ Headache/Blurred Vision _____
- ❑ Stroke _____
- ❑ Sinus Infection _____
- ❑ Asthma/Allergies _____
- ❑ Bronchitis _____
- ❑ Cough _____
- ❑ Emphysema _____
- ❑ Pneumonia _____
- ❑ Shortness of Breath (Dyspnea) _____
- ❑ Snoring _____
- ❑ Leg Swelling _____
- ❑ Congestive Heart Failure _____
- ❑ Coronary Artery Disease _____
- ❑ Heart Condition/Heart Disease _____
- ❑ High Blood Cholesterol _____
- ❑ High Blood Pressure _____
- ❑ Pain or Pressure in Chest _____
- ❑ Palpitations _____
- ❑ Stomach or Intestinal Problems _____
- ❑ Gastritis/Ulcers/Reflux _____
- ❑ Liver Problems/Hepatitis _____
- ❑ Kidney Disease/Excessive Urination _____
- ❑ Bladder/Kidney Infections _____
- ❑ Anemia/Bleeding/Abnormal Bruising _____
- ❑ Diabetes Type 1/Type 2 _____
- ❑ Increased Thirst _____
- ❑ Thyroid Problems _____
- ❑ Depression/Anxiety _____
- ❑ Skin Lesion _____
- ❑ Joint or Muscle Pain _____
- ❑ Sexual Dysfunction _____
- ❑ Breast Lumps/Menstrual Problems _____

FAMILY HISTORY: *(Please check all that apply)*

Cancer: ❑ Breast Cancer ❑ Prostate Cancer
❑ Colon/Rectal Cancer ❑ Skin Cancer
❑ Lung Cancer ❑ Other_____
❑ Ovarian Cancer _____

Heart Disease ■ Yes ❑ No
Diabetes ❑ Yes ❑ No
Cancer ❑ Yes ❑ No

IMMUNIZATIONS:
(Mark the year of last vaccine if known)

	YEAR
❑ Hepatitis A	_____
❑ Hepatitis B (Hep B)	_____
❑ Influenza	_____
❑ Pneumococcal vaccine	_____
❑ Tetanus and Diphtheria booster (Td)	_____

SCREENING TEST: YEAR
(Mark the year if known)

- ❑ Colonoscopy _____
- ❑ Mammogram _____
- ❑ Prostate Examination _____
- ❑ Bone Density

HEALTH HABITS AND BEHAVIORS:

- ❑ Exercise (Days/Week): _____
- ❑ Stress Level: ❑ Mild ❑ Moderate ❑ High

(Check substances that you use and how often)

- ❑ Tobacco (Packs/Day) _____
- ❑ Alcohol (Drinks/Week): _____
- ❑ Street Drugs: _____

I certified that the above information is correct to the best of my knowledge. I will not hold the doctor, ***Brandon Riverview Medical Associates*** or any member of its staff responsible for any errors or omissions that I may have made in the completion of this form: (*Please sign*):_____

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Demographic Questionnaire

To help assure quality care for all, federal mandates have been issued requiring capture of information on race, ethnicity and language data. New regulations from The Joint Commission, the Affordable Health Care Act, and CMS Medicare require physician offices to identify these health care disparities. By collecting this information, the federal government believes that it can ensure that all patients receive high-quality care.

We would appreciate it if you would complete this form. If there is any part you prefer not to provide, please mark the ***Decline*** checkbox.

Please check one item from each column:

Race	Language	Ethnicity
Select	Select	Select

_____ _____
Printed Name Date of Birth

_____ _____
Signature Date

BRANDON RIVERVIEW
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Our Financial Policy

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of one percent (1%) per month of an ANNUAL PERCENTAGE rate of (12%). The finance charge on your account is computed by applying the periodic rate (1%) to the "overdue balance" of your account. The "overdue balance" is calculated by taking the balance owed over thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is $ 0.50.

Past Due Accounts: If your account becomes past due we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which were incurred. If we have to refer collection of the balance to a lawyer; you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Hills-borough County Florida.

Returned Checks: There is a fee (currently $25.00) for any checks returned by the bank.

Electronic Funds Transfer: Patient authorizes Brandon Riverview Medical Associates to convert check and debit personal account for the sale amount via draft or Electronic Funds Transfer (EFT). In the event that the draft or EFT is returned unpaid, you agree to pay and have personal account debited electronically for an item fee of $25.00 plus any applicable taxes.

Missed appointment Fee: When you do not show up for an appointment, or you cancel with less than 24 hours notice, a $25.00 fee will be charged. The fee must be paid before a new appointment is scheduled. Patients with three (3) missed appointments may/will be asked to transfer their records to another doctor.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you receive treatment at our office may become a matter of public record.

Filling Paperwork: Any additional paperwork, such as FMLA/Disability, will require a fee of $25.00 to be prepaid. Please allow at least two (2) working days for us to complete such paperwork.

Transferring of Records: You will need to request, in writing, if you want a copy of your records; there may be a fee (maximum we could charge) of $6.50. You understand that it may take up to thirty (30) days to process your request for records. You authorize us to include all relevant information, including your payment history upon request. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Worker's Compensation: We require written approval/authorization by your employer and/or workers' compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment n full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to you initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patients' responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-Signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effect with any subsequent charges.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the patient authorizing treatment for a child will be responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parents' responsibility to collect from the other parent.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full effect.

Patient Signature Date

Legal Parent / Guardian Date

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NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we will honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health operations. You have the right to revoke this Consent, in writing, signed by you at any time. However, such revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that:

- Protected health information may be disclosed or used for treatment; payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right ti change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then be ceased

I have received, read, and understood the **NOTICE OF PRIVACY PRACTICES** for Brandon Riverview . I understand that if I have any questions I will contact the Privacy office regarding my concerns.

Patient Name (Print): _____ Date: _____

This Acknowledgement was signed by: _____
Patient Signature

Patient Representative/Guardian: _____
Patient Signature

For Office Use Only

Witness: _____ Date: _____
Practice Representative