Brandon Medical Care

New Patient Form

Name________________________________ Date of Birth___________

Today's Date__________ Age__________ Sex______

What name would you like to be called____________________

Marital status: single married divorced widowed

Occupation______________

Do you have allergies to medication, x-ray dyes or other substances: yes no
If yes, please list medication and
reaction____

____

Please list names of medication, dosage and reason for taking medications

____

____

____

____

____

Have you ever had surgery yes no
If yes, please list any surgeries

____

____

____

Immunizations
Date of Tetanus vaccine________
Date of Hepatitis B series________
Date of last pneumonia vaccine______

Date of TB screening_______
Date of last Flu vaccine_____

Health maintenance
Date of colonoscopy__________
Date of last pap smear________
Date of last eye exam_________

Date of last bone density_________
Date of last mammogram________

Do you wear seat belts? YES NO
Do you smoke cigarettes? Yes No
Do you drink caffeine? Yes No

Do you drink alcohol? Yes No
Do you use any illicit drugs? Yes No

Which of the following conditions are currently being treated or have been treated for in the past?

__Allergies
__Depression
__Emphysema/COPD
__Heart attack
__High blood pressure
__Gout
__Stroke
__High Cholesterol
__Asthma
__Alcoholism
__Back Pain
__Dizziness
__Erectile dysfunction
__Epilepsy/Seiures
__Heart murmur
__Bipolar disorder
__Hemorrhoids
__Insomnia
__Psoriasis
__Arthritis
__Acid reflux
__Anemia
__Headaches
__Schizophrenia
__ Heart disease
__Sinus disease
__Anxiety
__Cancer
__Diabetes
__Thyroid disease
__Other

Family History-Please list family member (mother, father Maternal/paternal grandparent)
Were you adopted? Yes No
Heart disease______________________________
High Cholesterol______________________________
High blood pressure______________________________
Diabetes______________________________
Heart Attack______________________________
Stroke______________________________
Liver Disease______________________________
Asthma______________________________
Anemia______________________________
Breast cancer______________________________
Lung cancer______________________________
Ovarian cancer______________________________
Other cancer______________________________
Thyroid disease______________________________
Drug/Alcohol addiction______________________________
Depression/anxiety______________________________
Suicide______________________________
Seizure/epilepsy______________________________
HIV/AIDS______________________________
Other:______________________________

Please list reason for today's visit______________________________

Previous PCP
Name____________
Address____________
Phone____________
Fax____________

Agreement for use of controlled substances

I understand that the main goal of treatment with chronic controlled substances is to improve my ability to function and/or work and/or reduce pain. In consideration of that goal, and the fact that I am being given potent medication to help me to reach that goal, I agree to help myself by following better health habits, including exercise, weight control, asfe sex avoiding the use of tobacco, alcohol, and illegal drugs/substances. Chronic controlled substance medication are intended to improve function and quality of life. I must comply with the treatment plan as prescribed by my provider. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment. Because my provider is prescribing such medication for me to help manage my diagnosis, I agree to the following conditions:

1. I am responsible for my controlled substance medications. If the medication(s) are lot, misplaced, or stolen, or if I use it up sooner the prescribed, **I understand that it may not be replaced.** I will noyt increase or decrease my dosage without talking with my provider.___

2. I will not request or accept controlled substance medication from any other provider or facility without notifying Brandon Medical Care, except in emergency or urgent health. The only exception is and emergency or urgent healthcare situation I will not allow anyone else to use my medication and will keep them secure.____

3. **Refills of chronic controlled substance medications should be:**

A. Will be made during regulat clinic hours. Refills will not be made at night, or on holidays or weekends.

B. Any exceptions such as I ran out early or **"I lost my prescription" or "I spilled or misplaced my medicine"** must be addressed by your provider. I am responsible for taking the medication in the dose prescribed, and for kiiping track of the amount remaing.

C. If I need assistance with a chronic controlled substance medication prescription, I will call to discuss this with my provider.____

4. My provider may require me to see qualified specialist anytime while I am receiving controlled substance medications. If I am unable to meet the requirements of this agreement, there may be medical and safety risks of continuing my controlled substance medication. I understand that my medications may not be continued or refilled.___

5. I agree to comply with random laboratory testing documenting the proper use of my medication and confirming compliance. I understand the importance of avoiding alcohol or other substances of abuse when taking a controlled substance medication. A positive test for any substance besides my prescribed medications will be grounds for action and/ or discontinuation of my medications.___

6. I understand that controlled substances can cause marked drowsiness. I will not drive a motor vehicle or operate dangerous equipment while I an sleepy. I understand that I will need to talk with my provider about my ability to drive or operate dangerous equipment. It is my responsibility to comply with the laws of the State of Florida while taking the medications prescribed.____

7. I understand that id I violate any of the above conditions, my controlled substance prescriptions may be tapered and not refilled, or ended immediately and alternative treatments for pain offered. I the

violation involves obtaining controlled substances from any other individual, as described above, or the use of street (illegal) drugs. I may be reported to my provider, medical facilities, and other agencies as appropriate.__

8. I understand that the long-term advantages and disadvantages of chronic opiate usage have yet to be scientifically determined. I understand that my treatment may change throughout my time as a patient. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substances, and that my provider will dicuss treatment changes with me as appropriate.__

I have been fully informed by Brandon Medical Care and staff regarding the probability of addiction to controlled substance, which I understanding is low.

I have read this agreement. By singing this agreement I hereby grant my provider the right to contact any other professional involved in my care concerning my use of opioid medications.

I fully understand the consequences of violating this agreement.

______________________	______________________
Name of patient	DOB
______________________	______________________
Patient signature	Date
______________________	______________________
Provider signatur	Date

Authorization to Release Confidential Information

I,________________________________(patient name)___/__/____ (date of birth), authorize ______________________ (doctor name/address or phone number) to disclose my health information to: **Brandon Medical Care 143 North Oakwood Ave Brandon ,Fl 33510PH: 813-732-8939 Fax: 813-933-8247 or** **Shital.Mehta@cit.ssdirect.aprima.com**

Patient must read and initial both sections A and B, then sign and date. Thank you.

A. I CONSENT TO THE RELEASE OF THE HEALTH INFORMATION BELOW:
______ All information
______ Only the information checked below:

___Clinical notes ___Lab and /or Radiology Reports ___Treatment Plan
___ Case Management Records ___History & Physical ___ Psychiatric Evaluation

Other (Specify):____

B. THE HEALTH INFORMATION DISCLOSE SHOULD INCLUDE THE FOLLOWING SPECIFIC HEALTH INFORMATION INITIALED BELOW:(___initial if waiving this section if not pertinent or do not authorize to disclose)
By placing initials next to a category of highly confidential information listed below, I specifically authorize the use and / or disclosure of the confidential information.

___Alcohol and/or drug abuse information ___HIV/Aids information ___Sexual Assault ___Mental Health records of information ___Abuse of an adult or child ___Developmental disability
If applicable, please add any limits (like by provider, date, service type)_______________________

This information is needed for the following purpose(s) Checked Below:

___Treatment ___Coordination of Care ___Case Management ___ PCP Communication

___Other (please specify)____

I understand that I may refuse or may revoke (at anytime) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation of care or quality of treatment. Unless revoked, this consent will expire on the following date, event or condition:_____. Otherwise, this consent will remain valid for twelve (12) months from date this consent was signed.

____
SIGNATURE OF PATIENT/PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE**

____
Date

____
PRINT NAME

** Relationship to Patient____

**If you are signing as the patient's legally authorized representative, please attach the appropriate legal documents (s) granting you the authority to do so (i.e., Health Care Power of Attorney, Court Order, etc.)

Brandon Medical Care
Financial Policy

We consider payment of services to be the responsibility of the patient-physician relationship. Therefore, we would like to share our payment policy expectations with you to ensure understanding and compliance.

We participate with various insurance companies and managed care plans, which we will file on your behalf directly to the insurance carrier for payment, less any co-payments, coinsurance, deductibles and non-covered benefits.

Please make sure that on your commercial managed plans that you choose us as your primary care providers. If we are not the doctors of choice, we will not be able to provide you with service in the office. Also, make sure that your insurance is active before making an appointment or you will be charged the full cost of the office visit.

Payment is expected at the time of service. We accept cash, check, Visa, MasterCard and Discover Card.

On all returned checks for non-sufficient funds, there is a $25.00 fee charged back to the patient. We will be unable to accept any personal checks until account balances and associated service fees are paid in full. If this becomes a repeated offense, we will only be able to accept cash.

By signing below, I have read and understand the payment terms and my obligations within the financial policy.

Thank you for understanding our financial policy. Please let us know if you have any additional questions or concerns.

____ ________________

Signature of patient or person responsible for account Date

HIPAA AUTHORIZATION FORM

Patient's Full Name ______________________ Patient's Social Security Number ______________________

Address ______________________ Patient's Date of Birth ______________________

City, State, Zip Code ______________________ Patient's Telephone Number ______________________

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specified person/class of person /facility is authorized to use or disclose information about me: ______________________
2. The following person (or entity) is authorized to request my protected health information subject to the limitations below:

   Name of Person/Entity ______________________

   Address ______________________

   City. State, Zip Code ______________________

   E-mail Address ______________________
3. The specific information that should be disclosed is (please give dates of service if possible):

   ____

   ____

   I authorize the disclosure of the following types of highly sensitive information: ___ drug and alcohol; ___mental health (psychiatric); ____HIV/AIDS testing and treatment.
4. I understand that the information used or disclosed maybe subject to re-disclosure by the person or class of person or facility receiving it and would then no longer be protected by federal privacy regulation.
5. I may revoke the authorization by notifying ______________________ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for ______________________.
7. This authorization expires on __________ 20___, OR upon occurrence of the following event that related to me or to the purpose of the intended use or disclosure of information about me:__________

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice. THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING-note that signature is required in two places*

Signature of Indiviual ______________________ **Date of Signature** ______________________ **Date of Birth** ______________________

Signature of Guardian or Representative ______________________ Date of Signature ______________________ Description of authority ______________________

Official Use Only

Received ______________________ Processed By ______________________ Log# ______________________

Brandon Medical Care

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 this carefully.

Purpose of privacy notice
This notice of privacy practices describes how we may use and disclose your protected health information to carry out treatments, initiate payment or conduct healthcare operations or for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected Health Information (PHI) is information about you, including demographic information that may identify you and that related to your past, present, or future physical and/or mental health or condition and related healthcare services.

This notice describes the privacy policies of our practice and that of: any healthcare professional authorized to enter information into your medical record including all employees of the practice.

Our pledge regarding medical information:
We understand that medical information about you and health is personal and we are committed to protected it. A record of the car and services you receive at this practice is created and maintained at this location. This notice applies to all of those records of your care.

We are required by law to make sure that medical information that identifies you is kept private. We will give you notice of our legal duties and privacy practices regarding your medical information. We will follow the terms of this notice currently in effect. We may change the terms of our notice at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling our office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

How we may use and disclose medical information about you:
The following categories describe ways that we use and disclose medical information.
Examples of each category are included and not every use or disclosure in each category is listed; however, all of the ways we are permitted to use and disclose information falls into one of these categories.
For treatment; We may use medical information about you to provide, coordinate or manage medical treatment and services. We may disclose medical information about you to other physicians or healthcare provider who are or will be involved in taking care of you.
For payment: We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed and payment may be collected from you, your insurance company, or third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval to determine whether your plan will cover treatment, or for undertaking utilization review activities.
For healthcare operations: We may use or disclose your PHI in order to support business activities for our practice. These activities include but are not limited to, quality assessment activities, employee review activities and conducting or arranging for other activities.

We may share your PHI with third-party "business associates" that perform various activities (billing) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of you PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

Sale or closure of practice: In the event that Brandon Medical Care is sold or acquired by another facility or physician group, your PHI will be disclosed to that group or entity.

Required by law, legal proceeding or law enforcement; We may use or disclose your PHI to the extent that the use of disclosure is required by law.

Public Health: We may disclose your PHI for public health activities and purpose to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury, or disability.

Communicable diseases: We may disclose your PHI to a health oversight agency for activities authorized by law such as audits, investigations and inspections, Oversight agencies seeking this information include government agencies that oversee the healthcare system, government benefit programs, or other governmental regulatory programs and civil rights law.

Health oversight: We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations and inspections, Oversight agencies seeking this information include government agencies that oversee the healthcare system, government benefit programs, or other governmental regulatory programs and civil rights law.

Your Rights
the following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.
You have the right to inspect and obtain a copy of your PHI about you that is contained in the designated records set for as long as we maintained the PHI.

You have the right to request a restriction of your PHI which means you may ask us no to disclose any part of your PHI for the purpose of treatment, payment or healthcare operations you may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes. Other uses or disclosures of your PHI will be made only with your written authorization unless otherwise permitted or required b y law as described below. You may revoke this authorization at any time, in writing, except to the extent that the practice hs taken an action in reliance on the use or disclosure indicated in the authorization.

We may use and disclose your PHI if the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines using professional judgment that you intend to consent to use or disclose under the circumstances.

You may have the right to have the practice amend your PHI. This means you may request an amendment of your information. In certain cases we may deny your request for amendment. You have the right to file a statement of disagreement with us and we may prepare a rebuttal of your statement and will provide you with a copy of any such rebuttal.

You have the right receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment payment or disclosures we may have made to you, to family members or friends involved in your care or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after January 1, 2006. You may request a shorter time frame. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our office administrator. We will not retaliate against you for filing a complaint.
Please place your initials ___________ Date __________________________

Living Wills – Advance Health Care Directives

A living will allows you to decide whether you desire life support under certain circumstances. It is a declaration that such procedures be withheld or withdrawn, and that you be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide you with comfortable care.

Living Will Legal Definition:

Adults in all States have the right to make decisions about their health care. They are given the right to accept or reject medical or surgical treatment after being informed of their options. Health care decisions can be made by you, or an agent you appoint to make decisions if you are not capable of making the decision at that time. Forms used for health care matters vary from State to State, but generally are one or more of the following: Living Will, Health Care Directive, Durable Power of Attorney for Health Care, health care proxy and others. A Living Well may also be called a Declaration, Living Will Declaration, Health Care Declaration, Health Care Directive, Advance Health Care Directive, Health Care Proxy and others. Sometime you will see the form named Statutory Living Will or Statutory Health Care Directive.

Living Wills:

Although the term Living Well may indicate that it is a Will, in reality, it is more similar to a Power of Attorney than a Will. Therefore, don't be confused by the title of the document. The purpose of a living will is to allow you to make decisions about life support and directs others to implement your desires in that regard.
Living Wills are needed because advances in medicine allow doctors to prolong and sustain life although the person will not recover from a persistent vegetative state. Some people would not desire to remain in that state while others would. Extending life when death is imminent to some people is only extending the suffering and prolonging the dying process.
The Living Will allows you to make the decision of whether life-prolonging medical or surgical procedures are to be continued, or withheld or with drawn, as well as when artificial feeding and fluids are to be used or withheld. It allows you to express your wishes prior to being incapacitated. Your physicians or health care providers are directed by the Living Will to follow your instructions. You may revoke the Living Will prior to becoming incapacitated.
The Living Will generally becomes operative hen it is provided to your physician or health care provider AND you are incapable of making health care decisions for yourself, such as where you are permanently unconscious or terminally ill and unable to communicate.

Durable power of attorney for Health Care
A durable power of attorney for health care is used to appoint an agent to make health care decisions for you and usually includes the power of the agent to make decisions regarding terminal conditions and whether to prolong life. However, if you have a Living Will, the directions of the Living Will control over the durable power of attorney, because you have already made the decision of what is to be done under certain circumstances. Many people use a Durable Power of Attorney for Health Care and a Living Will because they do not want to place the agent in the position of making decisions regarding choice in dying. The agent still ha authority to make other health care decisions for you when you cannot make the decision yourself in situations where you need medical attention but are not terminally ill or in a permanent coma.

Brandon Medical Care
143 N Oakwood Ave
Brandon, Fl 33510

Please let us know your wishes:

Check ALL that apply:

________ I have a living will. **(If yes, please provide a copy)**

________ I have a document that I signed that allows person to make healthcare decisions for me. **(If yes, please provide a copy)**

________ If I ever become too sick to make my own healthcare decisions, I give the following person permission to make them for me:

Name: ________________________________
Phone Number: ________________________

If I become so ill that I cannot tell my doctor what I want, and two doctors agree that they cannot make me better, please: (Check ALL that apply)

________ Keep me clean and free from pain.

________ Do NOT use tubes for: ____breathing ____feeding ____IV fluids.

________ Let my appointed person decide.

________ If my heart stops, do ____ do not ____ try to restart it.

________ Do EVERYTHING possible.

________ I do not wish to complete an advanced directive at this time.

Additional instructions:

____
____
____

Printed name: ________________________________ Date:__________

Signature: ________________________________ Date: __________

1st Witness: ________________________________ Date: __________
Relationship: ________________________________

2nd Witness: ________________________________ Date: __________
Relationship: ________________________________ Date: __________

Please note, the person designated as surrogate shall not act as a witness and at least one person who acts as a witness shall neither be the principal's spouse or blood relative.

Your surrogate may consult with your health care providers and give informed consent to perform medical procedures that the surrogate feels are in your best interest and make health care decisions. Your surrogate has access to your clinical records and has the authority to release information and records to appropriate person to ensure the continuity of your health care. If there is no indication of what you would have chosen, the surrogate may consider what is in your best interest in deciding that proposed treatments are to be withheld or that treatments currently in effect are to be withdrawn.

Brandon Medical Care
143 N. Oakwood Ave
Brandon FL. 33511
Ph: 813-734-8939 Fax: 813-933-8247

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 ("HIPPA"), I have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

2. Obtain payment from third-party payers.

3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I authorize disclosure of my protected health information for the named individual(s) listed below:

______________________________ ______________________
Name Relationship:

______________________________ ______________________
Name Relationship:

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ____________________

Authorization of Examination, Treatment, and Use/Disclosure of Protected Healthcare information (PHI) for Treatment, Payment, and Healthcare Operations Acknowledgment

I hereby authorize the physicians at Brandon Medical Care and staff to examine and/or render treatment. I understand that this may also include diagnostic imaging, use of scopes to examine Internal organs, and lab test (ie, blood-work, pathology, etc) I understand that I will receive explanation of ordered procedures/associated risks, and explanation of proper preparation for such procedures. I understand that I reserve the right to inquire about alternative courses of treatment and I will be given opportunity to have all of my questions answered.

I agree and understand that I have been provided with a Notice of privacy Practices that provides a description on how my PHI will be used and disclosed. I understand that Brandon Medical Care reserves the right to change any policies at any time. I understand that I have the right to object to the use of my PHI is disclosed to carry out treatment, payment, and healthcare operations and that the practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

With whom may we share you PHI (full name/relationship to Patient):

____

____

By singing below, I acknowledge that I have received the Notice of Privacy Practices for the uses/disclosures of my protected health information, the general Administrative and Financial agreement, and Authorization of Examination. I understand these documents in full and I have been given the opportunity to have all of my questions answered.

____
Print name

________________________________ ________________
Patient Signature Date

Power of attorney to endorse checks and/or to sign any piece of paper that will enhance or expedite payment to provider for services rendered, including but not limited to release of medical records and assignments of benefits/authorization to pay.

Known by all these present that: the undersigned has made, constituted and appointed, and by these presents hereby make constitute and appoint Brandon Medical Care and any of its duly authorized agents and employees and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks drafts or money orders which aqre made payable to the undersigned alone or to the undersigned and the said Brandon Medical Care which checks, drafts, or money orders are made payable for services which have been made by Brandon Medical Care at the request or with the knowledge and approval of the undersigned and/ or the maker of the check, draft or money order.

Furthermore, the undersigned allows Brandon Medical Care its agents to sing any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits or non-ownership of vehicles, insurance forms and other statements.

The undersigned by these presents does give and grant Brandon Medical Care, as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and chasing of said checks ar concerned as well as any other document.

Medical Release

A photocopy of these documents shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to Brandon Medical Care or any insured providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of the document shall be as binding as original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which they said attorney shall do or caus4e to be done by vitue of these presents

Authorization of Benefits

I, ______________________________ hereby authorize ______________________________
(Name of insured/patient) (Name of insurance carrier)
to make medical benefits payments otherwise payable to me for services rendered by Brandon Medical Care but not to exceed the charges of those services, payable to and mailed directly to:

Brandon Medical Care
143 N.Oakwood Ave
Brandon, FL. 33510

Furthermore, I hereby irrevocably assign to Brandon Medical Care, the rights and benefits under any policy of insurance, indemnity, agreement or any other collateral source as defined in Florida statues for any service and or charges provided by Brandon Medical Care.
In witness whereof the undersigned have hereunto set their hands, the ___ day of _____________,20__

_______________________________ _______________________________

Patient's name (Please Print) Patient's signature