Patient Registration

2016

# Brandon Area Primary Care

500 Vonderburg Dr 311W 282 Apollo Beach Blvd
Brandon, FL 33511-5978 Apollo Beach, FL 33572
www.brandondocs.com

Patient Acct#_____

Date: _____

## Patient Information

Email Address:_____@_____(for office use only)

Last Name: _____ First Name: _____ Middle initial: _____

DOB: _____ Sex: Male ☐ Female ☐ Social Security# _____ Marital Status: S M D W

Home Address: _____Apt# _____

City:_____ State:_____ Zip Code:_____

Northern/Alt. Address:_____Apt# _____

City:_____ State:_____ Zip Code:_____

Best # :_____ Home Phone: _____ Work:_____

Patient Employer:_____ Occupation:_____

Employer Address:_____ City:_____ State: _____ Zip:_____

Spouse's Name:_____ Social Security #:_____Date of Birth: _____

**In Case of Emergency**
Please notify:_____ Relationship to patient:_____ Phone:_____

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If patient is a minor please complete the following:

Name of Legal Guardian: _____Date of Birth_____

Social Security:_____

Home Address:_____Apt# _____

City:_____ State:_____ Zip Code:_____

**Child Resides with:**
☐ Both Parents ☐ Mother ☐ Father ☐ other_____

Parent/ Guardian Information: Pleas be advised that a minor child (under 18) will not Be treated with out a legal parent/guardian present. Legal guardian other than parent Must provide proof of guardianship. Please sign below.

Parent/ Guardian Signature:_____ Relationship:_____
Printed Name:_____

We are required to collect the following information for each patient. Thank You.

**Please Circle One**

**Race:** American Indian
Asian
Black or African American
Native Hawaiian
White
Decline to Answer

**Ethnicity:** Non- Hispanic or Latino
Hispanic or Latino
Other_____
Decline to Answer

**Preferred Language:** English
Spanish
French
Other:_____

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# Insurance Information

***Primary Health Insurance***

Insurance Name:_____Policy#_____Group#_____Eff Date:_____

Claims Address: _____ City_____ State:_____ Zip:_____

Policy Holder:_____ Policy Holder DOB_____ Policy Holder SS#_____

Policy Holder Employer:_____ Relationship to policy holder:_____

Policy Type (check one): ☐ HMO☐ PPO☐ Private

***Secondary/Other Health Insurance***

Insurance Name:_____Policy#_____Group#_____Eff Date:_____

Claims Address: _____ City_____ State:_____ Zip:_____

Policy Holder:_____ Policy Holder DOB_____ Policy Holder SS#_____

Policy Holder Employer:_____ Relationship to policy holder:_____

Policy Type (check one): ☐ HMO☐ PPO☐ Private

I hereby authorize Brandon Area Primary Care and its medical staff to perform medical procedure. I authorize the release of my medical information necessary for the processing of Insurance. I authorize the release of any medical information necessary to a physician to whom I am referred. A photocopy of the assignment of Financial Policy is to be considered as valid as an original. We cannot accept the responsibility for collection of your insurance claims nor for negotiating a settlement in a disputed claim. You are responsible for payment on your account.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE ABOVE, AND IS THE PATIENT, GUARANTOR, OR THE PATIENT'S REPRESENTATIVE DULY AUTHORIZED TO EXECUTE THIS AGREEMENT AND ACCEPT ITS TERMS.

Date: _____ Signature:_____
Signature of patient or Representative

_____ _____
Representative's Relationship (if other than patient) Witness

| NAME: | DOB: |
|---|---|

**ALLERGIES:** Are you allergic to any drugs? If so, please list:

☐ No ☐ Yes

**MEDICATIONS:** (List all medications you are taking regularly, including over the counter, herbal & natural remedies.)

**MEDICAL ILLNESSES OR CONDITIONS:** (that have been diagnosed)

_____ _____ _____

_____ _____ _____

**OPERATION(S):**

Year Surgery

____ _____

____ _____

____ _____

**HOSPITILIZATIONS:** (other than Operations)

Year Surgery

____ _____

____ _____

____ _____

**FAMILY MEDICAL HISTORY**

| RELATIVE | AGE | HEALTH (list significant illnesses) | AGE AT DEATH | IF DECEASED, CAUSE | COMMENTS |
|---|---|---|---|---|---|
| Father | | | | | |
| Mother | | | | | |
| Brother(s) | | | | | |
| | | | | | |
| Sister(s) | | | | | |
| | | | | | |
| Spouse | | | | | |
| Child(ren) | | | | | |
| | | | | | |

**HAS ANY BLOOD RELATIVE EVER HAD?** (Check Yes - Indicate Relationship)

☐ Alzheimers _____ ☐ Heart Attack before age 55 _____ ☐ Tuberculosis _____

☐ Diabetes _____ ☐ Bleeding Disease _____ ☐ Stroke _____

☐ Seizures _____ ☐ High Blood Pressure _____ ☐ Heart Disease _____

☐ Asthma _____ ☐ Depression/Suicide _____ ☐ Cancer _____

☐ Allergies _____ ☐ Mental Disorder _____ ☐ Alcoholism _____

**IMMUNIZATIONS:** (Check - if yes, indicate year of injection)

☐ Influenza _____ ☐ Pneumonia _____ ☐ MMR _____ ☐ Telenus _____ ☐ Hepatitis A/B _____ ☐ Other _____

| SIGNATURE: | DATE: |
|---|---|

# ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

**I AUTHORIZE** the release of any medical information, including without limitation, information related to psychiatric care, drug abuse, alcohol abuse, or **HIV/AIDS** confidential information that is needed for submission to my insurance carrier in order to process a claim or for utilization review or quality assurance activities.

**I ASSIGN** all medical and/or surgical benefits including major medical benefits to which I am entitled to **Brandon Area Primary Care**. A photocopy of this authorization shall be effective and valid as the original.

**I AGREE** to accept responsibility for any balance remaining after insurance pays or, if an HMO participant, any appropriate co-payment, deductible, or non-covered service. If I do not have insurance coverage, I agree to adhere to payment arrangements made at the time of my appointment, and to be responsible for any legal fees, cost, and expenses incurred by **myself** in the pursuit of the collection of fees due them for service provided.

I understand that this form or a copy thereof is valid for twelve (12) months.

| | |
|---|---|
| _____ | _____ |
| Date Signed | Patient/Subscriber Signature |

**YEARLY UPDATES**

| | |
|---|---|
| _____ | _____ |
| Date Signed | Patient/Subscriber Signature |
| _____ | _____ |
| Date Signed | Patient/Subscriber Signature |
| _____ | _____ |
| Date Signed | Patient/Subscriber Signature |
| _____ | _____ |
| Date Signed | Patient/Subscriber Signature |
| _____ | _____ |
| Date Signed | Patient/Subscriber Signature |
| _____ | _____ |
| Date Signed | Patient/Subscriber Signature |
| _____ | _____ |
| Date Signed | Patient/Subscriber Signature |

## *What do I need to fill out a Living Will or a Power of Attorney?*

Basically, all that is needed is a copy of the form authorized by state law or a document which is consistent with the statute. The use of a statutorily authorized form is recommended to avoid questions related to the appropriateness of the form.

## *Whom may I appoint to be my agent under a Power of Attorney?*

This is a personal decision and should be considered very carefully. With certain exceptions, law permits you to appoint anyone of your choosing, with the exception of any person who is providing you health care.

## *What authority does my agent have to act on my behalf?*

Your agent will only have that authority which you specifically designate to her or him in the Power of Attorney document. The powers which may be granted to your agent are spelled out in the Power of Attorney document and should be considered carefully.

## *Once I execute a Living Will or Power of Attorney, can I change it?*

Yes. A Living Will or Power of Attorney can be changed or revoked at any time. You should destroy the current document and execute a new document which details your new directions.

## *Whom should I notify that I have a Living Will or Power of Attorney?*

You should notify your physician of the existence of a Living Will or Power of Attorney and have her or him place a copy of it in your medical record. You may also wish to inform members of your family or any close friends of its existence so they will know your wishes should the need arise. If you have appointed an agent under Power of Attorney, you should notify that person (or persons) and you may wish to have them sign the Power of Attorney.

You may obtain the advance directive forms described in this brochure by contacting your attorney, local medical society or hospital association.

# PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

Name of Patient _____ Date of Birth _____

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745. Florida Statutes, please answer the following questions:

Declaration to Decline Life-Prolonging Protection (Living Will)

- ☐ I have made such a declaration.
- ☐ I have NOT made such a declaration.

Health Care Surrogate

- ☐ I have designated a Health Care Surrogate.
- ☐ I have NOT designated a Health Care Surrogate.

Durable Power of Attorney

- ☐ I have appointed a Durable Power of Attorney for Health Care decisions.
- ☐ I have NOT appointed a Durable Power of Attorney for Health Care decisions.

Date _____ Signature of Patient or Representative _____

YEARLY RECONFIRMATION

| | |
|---|---|
| Signature of Patient or Representative Date | Signature of Patient or Representative Date |
| Signature of Patient or Representative Date | Signature of Patient or Representative Date |
| Signature of Patient or Representative Date | Signature of Patient or Representative Date |

# SUMMARY OF PRIVACY PRACTICES

**This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length Notice follows this summary.**

Date of Last Revision: _____

Effective Date: _____

***This information is made available on request by a patient***

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. *A copy of any and all notices are available at the front desk.*

**We understand that your medical information is personal to you,** and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

**How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices that follows this summary):**

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

**If you believe your privacy rights have been violated,** you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

- The right to inspect a copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

For more information about these rights please see the detailed Notice of Privacy Practices that follows this summary.

# PATIENT QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

_____

_____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IF AN EMERGENCY:

Name _____ Phone Number _____

Name _____ Phone Number _____

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

_____

_____

IV. Please indicate if you want all correspondence form our office sent in a sealed envelope marked "CONFIDENTIAL."

YES_____ NO_____

V. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number: _____

VI. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?

YES_____ NO_____

PATIENT NAME _____(guardian if under 18 years)

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

_____

PHARMACY NAME & LOCATION

## PATIENT ACKNOWLEDGEMENT FORM

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 shall 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 care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on you prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPAA).

The patient understands 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 to 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 cease
- The Practice may condition treatment upon the execution of this Consent.

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This Acknowledgement was signed by: _____
Patient or Legal Representative

Relationship to Patient (if other than patient): _____

Date:_____/_____/_____

Witness _____
Printed name - Practice representative

Date:_____/_____/_____

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## Billing Guidelines

*Brandon Area Primary Care billing polices and a representative list of potential fees and charges are outlined below. This information is to ensure you are better informed at the time of service, and prior to the arrival of a billing statement. Please speak with the office manager if you have any questions regarding this information.*

- **Co-Pays:** It is our policy to collect your insurance co-pay at check in. This simplifies the office process and ensures the financial obligation is met at the time of service.

- **Co-Insurance /Deductibles:** Every effort is made to fairly estimate the co-insurance or deductible owed based on the nature of the visit. It is our policy to collect these payments at the time of service.

- **Self-Pay Patients-** For patients without insurance $50 will be collected upfront for estimated charge. If charges excesses $50 dollars remaining balance will be collected at check out.

- **Billing:** As a courtesy, Brandon Area Primary Care bills your health insurance provider on your behalf.
  - **Insurance ID Card:** It is critical that the most current insurance ID card is brought to every appointment. We must have the correct information at the time of service.
  - **Auto Injury/Slip & fall/Third party-** We do not see patients or bill insurance for visits and medical care related to an auto injury/slip & fall/Third party accident. We can refer you to a facility without being seen by us to assist you with those issuses.
  - **Disability-** we do not fill out any disability forms for total disability. We will only do short term FMLA.
  - **Combined Visits-** If you are scheduled for a well exam (physical), and other health concerns are brought up that would typically require a sick visit, your insurance company may consider these two separate visits and bill your co-pay and other charges accordingly.
  - **Afterhours/Weekend surcharge-** Some health insurance providers bill a surcharge if you see your physician after normal business hours (8-5 pm), or on weekends (Saturday appointments).

- **Administrative Fees:**
  Brandon Area Primary Care charges fees for the following administrative tasks. (fees subject to change)

  - **Copies/Medical records:** $1 per page for first 25 pages and .25 cents for each additional page.
  - **Completion of forms:** FMLA, Sports/School physicals are free during a visit otherwise **$25.00**
  - **Physician letters:** ..... **$25.00**
  - **Return Checks:** (for insufficient funds) ..... **$20.00**
  - **"No-show" Fee:** Assessed if you do not show up for a scheduled appointment..... **$30.00**

- **Appointments:** As a courtesy, Brandon Area Primary Care provides a reminder call for your appointments, but this service is not always available. Our office must be notified at least 24 hours in advance, during business hours, if you intend to cancel an appointment.
- **Same-day appointments:** Our office must be notified of cancellation as least 4 hours in advance.

**Our answering service does not accept appointment cancellations**

_____ _____ _____

*Patient/Guardian Name (print)* *Signature* *Date*

# Brandon Area Primary Care

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In order to continue to provide you with the best service for your health care needs, effective August 1st, 2013 you will be given this form to read, sign and date.

In accordance with ACA (The Association of Credit and Collection Professionals) per the Telephone Consumer Protection Act you agree, in order for us to render service to you and access your account or to collect any amounts you may owe in the event there are charges not covered under your insurance company. We may contact you by phone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you (by your wireless carrier).We may also contact you by sending text messages or e-mails address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I have read this disclosure and agree that Brandon Area Primary Care and/or it's representatives may contact me as described above.

| Patient Name (Print) | Signature | Date |
|---|---|---|

| Witness | Date | Account# |
|---|---|---|

# Brandon Area Primary Care

Stephen D. Parks, M.D.
Jason C. Stibich, M.D.
Natassa L. Quinn, D. O.
John A. Morrison, M.D.

B. Mack Knowles, PA-C
Paula S. Proch, PA-C
Vanessa Guerrero, PA-C
Scott McLaurin, PA-C

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To: All Patients of Brandon Area Primary Care
From: Stephen D. Parks, M.D. and Staff

Dear Patient:

Welcome to Brandon Area Primary Care. The Following information will help us better serve you.

In accordance with the Health Insurance Portability and Privacy Act (HIPPA) and to ensure your ultimate privacy and confidentiality in this practice, only the patient will be allowed back in the exam rooms. *However, if the patient is a minor child or the person with communication difficulties, one person may accompany the patient*. Please understand that this is to ensure your ultimate privacy and confidentiality while you are a patient in this practice.

Listed below is information regarding your prescriptions, referrals and lab test results:

**Prescriptions**

1) Please bring your bottles of prescription medication with you to every visit.
2) If you need a refill , we will be glad to refill your prescription at the time of your visit.
3) If you need refills at any other time, please call our dedicated **Prescription Refill Line**
   **Brandon patients** please call (813) 654-8895. **Apollo Beach patients** please call (813) 641-9882.
4) Please allow 48 hours notice to refill your prescription, not including weekends.
5) On occasion, you will be requested to see the doctor before refilling your medications over the phone.
6) Please be advised: Narcotic medications and many Antibiotics **cannot** be filled over the phone.

**Referrals for Managed Care Companies (HMOs)**

1) Please allow us a minimum of 3 working days to process your referral to a Managed Care Company.
2) Some referrals may take longer, in which case we will make every effort to contact you.
3) Please leave appropriate information on the dedicated **Referral Line**
   **Brandon patients** please call (813) 654-8895. **Apollo Beach patients** please call (813) 641-9882.

**Lab Test Results (X-Ray, Lab, etc.)**

1) Obtaining and processing your results take time. You can expect your results in writing within 1 to 2 weeks. If you do not receive a note from us within 2 weeks, please call our office.
2) Mammogram reports often take 2 or more weeks. Pap smear reports can take up to 6 weeks.

We appreciate your cooperation in the above matters.

Sincerely,

Stephen D. Parks, M.D.

PLEASE COMPLETE HIGHLIGHTED AREAS. Keep for your records any pages without highlights.

# PATIENT RIGHTS

## THIS DESCRIBES YOUR RIGHTS AND THE OBLIGATIONS OF THIS PRACTICE REGARDING THE USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION.

You have the following rights regarding your medical information maintained by this office:

- **Right to Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes your own medical and billing records, but does not include psychotherapy notes. Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed.

  To inspect and copy your medical records, you must submit your request in writing to our Compliance Officer. As the front desk person for the name of the Compliance Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies (tapes, disks, etc.) associated with your request.

  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 our Compliance Committee review the denial. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome and recommendations from that review.

- **Right to Amend:** If you feel that the medical information we have about you in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the Practice maintains your medical record.

  To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated and signed by you and notarized.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for the Practice;
  - Is not part of the information which you would be permitted to inspect and copy; or,
  - Is inaccurate and incomplete.

- **Right to an Accounting of Disclosures:** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you, to others.

  To request this list, you must submit your request in writing. Your request must state a time period not longer than six (6) years back and may not include dates before April 14, 2003 (or the actual implementation date of the HIPPA Privacy Regulations). Your request should indicate in what form you want the list (i.e. paper, electronically). We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to 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 health care 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 or the payment for your care (a family member or friend). For example, you could ask that we not use or disclose information about a particular treatment you received.

  *We are not required to agree to your request and we may not be able to comply with your request.* If we do agree, we will comply with your request except that we shall not comply, even with a written request, if the information is excepted from the consent requirement or we are otherwise required to disclose the information by law.

  To request restrictions you must make your request in writing. In your request indicate:

  - What information you want to limit;
  - Whether you want to limit our use, disclosure or both; and,
  - To whom you want the limits to apply, (e.g., disclosures to your children, parents, spouse, etc.)

- **Right to 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 may ask that we only contact you at work or by mail, that we not leave voice mail or e-mail, or the like.

  To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all *reasonable* requests. Your request must specify how or where you wish us to contact you.

- **Right to 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.