Bayfront Health Medical Group

Dear Patient,

Our practice is honored that you have chosen Bayfront Health Medical Group. You have chosen the best, most caring, most technologically advanced practice in Hernando and Pasco Counties and beyond! We strive to perform well above other offices you may have visited in the past, and we hope you will notice the many ways in which we are different. We work to always smile for our patients. Everything we do is intended to efficiently deliver to you the best care possible, in a legal and ethical manner. Barring an emergency, your appointment will be on-schedule, so please be on time and turn in your paperwork as soon as possible. Please ask if you have questions regarding any of our policies or procedures.

Because we make every effort for your appointment to be at the scheduled time, it is very important that we receive these forms one week prior to your visit. If they are not returned complete before your appointment, it is possible that you will have to reschedule. Please fill in ALL blanks, whether or not they apply to you. We prefer that you fax the completed forms to the office you have selected, or you can mail to or drop off at any of our office locations. Please pay special attention to all policies listed, as you are agreeing to adhere to them.

Completing Forms and Copying Charts

There is a $20 charge for each disability, FMLA, or other medical form to be completed. We ask for 7 days to complete the form. To obtain a copy of your chart, you may incur a fee and we ask for 30 days to complete request.

Deductibles and Refunds:

If your deductible has not been met you will be responsible to pay at the time of service until the deductible is met. If there is an overlap in payments we will issue a refund upon request, or you may apply it to a future visit.

Missed Appointments:

There may be a **$25 charge for a missed appointment** unless you advise us one business day prior to your appointment. Being more than 15 minutes late is considered a late cancellation, and is subject to the same fee.

Payment:

Payment is due at the time services are rendered. We accept cash, credit cards and checks. Per our contracts with the insurance companies we must collect all co-pays prior to your office visit, or your visit will need to be rescheduled. If we are a contracted provider with your insurance company and are able to verify and confirm coverage, you will only be responsible for your co-pay and deductible at the time of your visit. Please note: Verification of coverage is not a guarantee of coverage. You will be considered responsible for all visits, labs, and procedures not covered by your insurance. As insurance companies frequently misquote benefits, you are ultimately responsible to know your policy's terms.

Percentages due (co-insurance):

If your insurance policy only pays a percentage of your visit or surgery an estimate of your amount owed must paid the day of your visit or prior to your surgery. The percentage is based upon the allowed amount. If there is an over payment we will refund the difference to you upon request or it will be applied to future visits.

Returned Check Policy:

NSF checks or others returned to us will require complete payment in cash or certified funds for the amount of the check PLUS any fees allowed by Florida law.

Your satisfaction with our care is our priority. We are very excited to have you in our practice and look forward to our future relationship. By signing below, you are acknowledging a full understanding of the policies listed above.

Patient/Guardian Signature_____

Date_____

PATIENT'S REGISTRATION INFORMATION

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____Cell Phone: _____ Work: _____

Email: _____ Social Security Number: X X X - X X - _ _ _ _

Race: ☐Black/African American ☐Other Race ☐Pacific Islander ☐Patient declined information ☐White or Caucasian

Ethnic Group: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Patient declined information

Emergency Contact: _____ Relationship: _____ Phone: _____

Employer: _____ Address: _____ Phone: _____

Primary Physician: _____

Preferred Pharmacy (with cross streets):_____

Mail Order Pharmacy: _____ Address: _____

Preferred Imaging Facility: _____

INSURANCE INFORMATION – Please fill in ALL blanks.

Policy Holder's Name: _____ Date of Birth: _____

Insurance Company: _____

Insurance Claims Address: _____

Insurance Company's telephone number: _____

Group/Policy #: _____ Subscriber/ID #: _____

ONLY IF PATIENT IS A MINOR – RESPONSIBLE PARTY INFORMATION – Please fill in ALL blanks.

First Name: _____ MI: _____ Last Name: _____

Sex: ☐ M ☐ F Date of Birth: _____ Phone: _____

Address: _____City: _____ State: _____ Zip Code:_____

Minor Pre-Authorization for Medical Care

I request and authorize Brooksville HMA, LLC and its personnel to deliver medical care to my child listed below.

Guardians Name (Print):_____ Guardians Signature: _____

Relationship to patient (Print): _____ Date: _____

General Consent to Treat/Patient Authorization/Acknowledgement of Benefits Release/e-Prescribing/Medication

The following are the conditions for services provided by Brooksville HMA Physician Management, LLC for the patient whose name appears at the bottom of this page.

Consent for Medical Treatment: I/we voluntarily consent to medical treatment and diagnostic procedures provided by Brooksville HMA Physician Management, LLC and its associated physicians, clinicians and other personnel. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

Authorization for Release of Information: The practice and physicians are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning and further medical treatment, to disclose to my employer (if seen for work related exam or injury) insurance and/or any third party payer all medical information, test results and findings made during the course of this examination and/or treatment. To include information referring to psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/we also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law.

Assignment of Insurance Benefits: I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and Brooksville HMA Physician Management, LLC. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits.

Acknowledgement of Receipt of Notice of Privacy Practices: I/we have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice maybe changed at any time.

I authorize discussion of my general medical condition and diagnosis (including treatment, payment, and health care options) with: ☐ Spouse ☐ Children ☐ No One ☐ Other _____

Can we leave a message on your answering machine or voice mail concerning **normal** lab results, appointment reminders, or other questions? I (the patient) understand that answering machines and cell phones are not secure lines. ☐ Yes ☐ No

I understand that Brooksville HMA Physician Management, LLC may send postcards or leave voice mail messages for appointment reminders.

I certify that I am the patient or the patient's duly authorized representative and that the information given by me to Provider in applying for payment under Medicare and/or Medicaid programs, insurance plans, or other protection is correct and complete. I understand, acknowledge and agree to the terms set forth above.

Signature: _____ **Date:** _____

Printed Name _____

e-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- Formulary and benefit transactions – gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification – allows the prescriber to receive an electronic notice from the pharmacy telling them if patient's prescription has been picked up, not picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that BROOKSVILLE HMA PHYSICIAN MANAGEMENT LLC can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to BROOKSVILLE HMA PHYSICIAN MANAGEMENT LLC to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Signature: _____ **Date:** _____

Name_____ Date of Birth_____

Check, circle or fill in ALL answers (*you may mark more than one choice*). Please mark "None" if no other choice pertains to you.

Allergies to Medications and Reaction _____
_____

Medications with dosages _____
_____
_____

Vaccinations and Dates Completed: _____

Gynecological History

Age menstrual cycle started___
Is flow-Light Moderate Heavy
Current birth control type_____
STD/PID- yes or no

Monthly menstrual cycle- yes or no
How many days cycle lasts_____
If Hysterectomy, reason_____
If postmenopausal age at menopause___

Frequency of cycle_____
Cramps- yes or no
Age when had 1st child____

Hormone Replacement Therapy- yes or no
Date of last menstrual period_____
Date of last mammogram_____
Date of last bone density_____
History of abnormal mammogram- yes or no
Fibroids of uterus- yes or no
Endometriosis- yes or no
Postmenopausal bleeding- yes or no
Sexually active- yes or no

Date of last Pap_____
Date of last Colonoscopy_____
History of abnormal pap- yes or no
Breast lump- yes or no
Total lifetime# of sexual partners_____
History of ovarian cysts- yes or no
Sexual problems- yes or no

Obstetrics History

Total # of pregnancies____
Total # abortions induced_____
Total # ectopic_____

Total # full term_____
Total # abortions spontaneous___
Total # multiple births_____

Total # premature_____
Total # living children_____

Past Pregnancies

Baby #1 Date of birth_____ # of fetuses_____
Full term, premature, abortion induced, abortion spontaneous or ectopic Boy/Girl Weight_____
Delivery type- vaginal, c-section, other_____ Gestational weeks_____
Preterm labor- yes or no Complications_____

Baby#2 Date of birth_____ # of fetuses_____
Full term, premature, abortion induced, abortion spontaneous or ectopic Boy/Girl Weight_____
Delivery type- vaginal, c-section, other_____ Gestational weeks_____
Preterm labor- yes or no Complications_____

Baby#3 Date of birth_____ # of fetuses_____
Full term, premature, abortion induced, abortion spontaneous or ectopic Boy/Girl Weight_____
Delivery type- vaginal, c-section, other_____ Gestational weeks_____
Preterm labor- yes or no Complications_____

Baby#4 Date of birth_____ # of fetuses_____
Full term, premature, abortion induced, abortion spontaneous or ectopic Boy/Girl Weight_____
Delivery type- vaginal, c-section, other_____ Gestational weeks_____
Preterm labor- yes or no Complications_____

Family Medical History (any serious illness, for example, diabetes, heart problems, cancer…) **Please be sure to include below if you have an Aunt with breast or ovarian cancer**

Mom_____
Dad_____
Brother_____
Sister_____
Maternal grandmother _____
Maternal grandfather _____
Paternal grandmother _____
Paternal grandfather _____
Maternal Aunt _____
Maternal Uncle _____
Paternal Aunt_____
Paternal Uncle _____
Other Relation _____

Name_____ Date of Birth_____

Social History

Smoking/Tobacco Use
☐Never ☐Former Smoker ☐ Current every day smoker ☐ Current some day smoker
Smokeless Tobacco Use- yes or no ____packs/can per day/week Years of Tobacco use____

Marital status
☐Married ☐Single ☐Divorced ☐Separated ☐ Widowed ☐Domestic Partner

Alcohol use
☐NONE ☐Occasional ☐Moderate ☐Heavy

Drugs Are you CURRENTLY using:
☐NONE ☐Marijuana/Spice ☐Heroin ☐LSD ☐Cocaine
☐Prescriptions abuse ☐Methadone

Exercise
☐ None ☐Occasional ☐Moderate ☐Heavy

Diet
☐Regular diet ☐Vegetarian ☐Vegan ☐Gluten Free ☐Specific ☐Low Carb
☐Cardiac ☐Diabetic

Sexual or Physical Abuse
☐NONE ☐Raped ☐Abuse as a child ☐Incest ☐Physical abuse in past
☐Physical abuse currently

Sexual history
Active with: ☐Heterosexual ☐Homosexual ☐Bisexual

Surgery
☐NONE ☐Appendix ☐Tonsils ☐Gallbladder ☐D&C
☐Abortion ☐Tubal ligation ☐Laparoscopy ☐Bladder suspension ☐Lumpectomy
☐Colon removed ☐Mastectomy ☐Hemorrhoidectomy ☐Hernia Repair ☐Orthopedic
☐Hysterectomy only ☐Hysterectomy + Ovaries ☐Other _____

Medical History

Do you currently have or have you had any of the following

☐NONE	☐Asthma	☐Atrial fibrillation	☐Adult onset diabetes
☐Anxiety	☐Arthritis	☐Breast cancer	☐BV (Bacterial Vaginosis)
☐Bipolar	☐Bronchitis	☐Bipolar disorder	☐Cancer (type) _____
☐Chicken Pox	☐COPD	☐Compulsive disorder	☐Colon cancer
☐CMV	☐Depression	☐DVT	☐Elevated lipids
☐GERD	☐Glaucoma	☐Heart attack	☐Hypertension
☐Heart disease	☐Hepatitis B or C	☐HIV/AIDS	☐Hypothyroidism
☐Infertility	☐Kidney disease	☐Kidney Infection	☐Kidney Stones
☐Lung cancer	☐Liver disease	☐Measles	☐Melanoma
☐Migraines	☐Osteoporosis	☐Osteoarthritis	☐Rheumatic fever
☐Seizures	☐Mitral valve prolapse	☐Neurological disorder	☐PMS/PMDD
☐Sleep Disorder Insomnia		☐Suicide attempt	☐Urinary tract infections
☐Yeast Infection			

Accidents/Hospitalization

☐No injuries	☐Car accident	☐Motorcycle	☐Head injury
☐Fracture	☐OB only	☐Illness_____	