MAB
MEDICAL ASSOCIATES OF BREVARD

New Patient Registration

Patient Information

Patient Name

_____
First MI Last

DOB ___/___/_____ SS# _____

Marital Status_____ ◯ MALE ◯ FEMALE

Address _____

_____

Home Phone _____ Cell _____

Work Phone _____

Employer _____

Occupation _____

Name of Spouse _____

Address: _____

_____

◯ Check if same as patient's address

Race
◯ American Indian or Alaska Native ◯ Asian
◯ Native Hawaiian ◯ Black or African American ◯ White
◯ Other Pacific Islander ◯ Prefer not to answer

Ethnicity
◯ Hispanic/Latino ◯ Non-Hispanic/Latino
◯ Prefer not to answer

Preferred Language
◯ English ◯ Spanish ◯ French ◯ Indian (includes Hindu & Tamil) ◯ Other _____

Preferred Pharmacy _____

Location _____

Family Doctor _____

Phone _____

Insurance Information

Primary Insurance Co _____

Policy #: _____

Policy holder information, if not same as patient:

Name _____

DOB ___/___/_____ SS# _____

Secondary Insurance Co _____

Policy #: _____

Policy holder information, if not same as patient:

Name _____

DOB ___/___/_____ SS# _____

Complete below if patient is a minor

Father's Name (or Guardian) _____

DOB ___/___/_____ SS# _____

Home Phone _____ Cell _____

Work Phone _____

Address: _____

_____

◯ Check if same as patient's address

Employer _____

Mother's Name (or Guardian) _____

DOB ___/___/_____ SS# _____

Home Phone _____ Cell _____

Work Phone _____

Address: _____

_____

◯ Check if same as patient's address

Employer _____

MAB
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New Patient Registration

HIPAA Release

Patient Name

First MI Last

Do you have a Living Will? ◯ Yes ◯ No
Do you have an Advance Directive? ◯ Yes ◯ No
If you answered yes to either, please provide us a copy.

Emergency Contact:

Name Relationship

Phone #

I authorize Medical Associates of Brevard LLC to discuss my healthcare information with the below:

Name Relationship

Phone #

Name Relationship

Phone #

Preferred appointment reminder notification:
◯ Home Phone ◯ Cell ◯ Cell Text ◯ Work phone
◯ Mail ◯ E-Mail ◯ None
◯ With the person(s) authorized above

Preferred medical information notification:
I authorize Medical Associates of Brevard LLC to leave a detailed message which may contain personal health information via:
◯ Home Phone ◯ Cell ◯ Cell Text ◯ Work phone
◯ Mail ◯ E-Mail ◯ None
◯ With the person(s) authorized above

Note that authorization to contact via phone includes authorization for us to leave a message on your voicemail or answering machine.

Your HIPAA contact information will be recorded as you have indicated here. You will be asked to electronically sign to confirm this information.

MEDICAL HISTORY FORM

PATIENT NAME:_____ DATE OF BIRTH:_____

BRIEFLY DESCRIBE THE PROBLEM THAT BRINGS YOU TO THE OFFICE TODAY:
(FOR EXAMPLE: RIGHT HEEL PAIN, INGROWN NAIL LEFT BIG TOE, INJURY LEFT ANKLE)

PLEASE CIRCLE IF YOU HAVE EVER HAD ANY OF THE FOLLOWING:

ANEMIA	HIGH BLOOD PRESSURE	DEPRESSION AND/OR ANXIETY
ASTHMA	HIGH CHOLESTEROL	STROKE / TIA
PERIPHERAL VASCULAR DISEASE (POOR CIRCULATION)	KIDNEY DISEASE ON DIALYSIS?	STOMACH ULCERS
BLEEDING DISORDERS		REFLUX DISEASE (GERD)
USE BLOOD THINNERS COUMADIN/WARFARIN PRADAXA	LUNG DISEASE COPD EMPHYSEMA	ARTHRITIS DEGENERATIVE (OSTEOARTHRITIS) RHEUMATOID
BACK PROBLEMS CERVICAL LOW BACK PAIN SCIATICA HERNIATED DISCS OTHER:	HEART DISEASE HEART ATTACK CONGESTIVE HEART FAILURE CORONARY ARTERY DISEASE ATRIAL FIBRILLATION MITRAL VALVE PROLAPSE PACEMAKER OTHER:	CANCER TYPE: TREATMENT:
DIABETES - YEAR DIAGNOSED:	EPILEPSY/SEIZURES	
GOUT	THYROID PROBLEMS	LIVER DISEASE: HEPATITIS OR JAUNDICE
BLOOD CLOTS	FIBROMYALGIA	PSORIASIS
WOUND HEALING PROBLEMS	MRSA INFECTION	NEUROPATHY/NERVE PROBLEMS

☐ NO KNOWN MEDICAL PROBLEMS
ANY OTHER MEDICAL CONDITIONS NOT LISTED ABOVE:

PRIOR FOOT OR ANKLE PROBLEMS?: IF SO, DESCRIBE:

PLEASE LIST ALL PRIOR SURGERIES WITH DATES: ☐ NO PRIOR SURGERIES
☐ HEART (STENTS OR BYPASS) DATE:
☐ VASCULAR/LEGS- (STENTS OR BYPASS) DATE:
☐ PRIOR FOOT OR ANKLE SURGERY, PLEASE DESCRIBE:

ANY OTHER SURGERIES:
_____
_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, BIRTH CONTROL PILLS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

_____
_____
_____

REFERRAL SOURCE:_____ **PRIMARY DOCTOR**:_____

PLEASE LIST ALL ALLERGIES: ☐ NO KNOWN ALLERGIES

☐ PENICILLIN ☐ SULFA ☐ CODEINE ☐ NSAIDS ☐ ASPIRIN ☐ LATEX ☐ ADHESIVE TAPE ☐ IODINE

ANY OTHER ALLERGIES NOT LISTED ABOVE:

_____

PLEASE LIST ANY HOSPITALIZATIONS IN LAST 2 YEARS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE
_____		_____	
_____		_____	

SOCIAL HISTORY:

FOR CHILDREN: GRADE IN SCHOOL _____ SPORTS/ACTIVITIES _____

FOR ADULTS: OCCUPATION: _____ EMPLOYER: _____

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE _____ PACK(S)/DAY FOR _____ YEARS

ALCOHOL CONSUMPTION: ☐ NEVER ☐ OCCASIONAL ☐ MODERATE ☐ DAILY
☐ HISTORY OF ALCOHOL ABUSE

EXERCISE: ☐ NEVER ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

FAMILY HISTORY:

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER, TYPE _____
☐ HEART DISEASE ☐ STROKE ☐ RHEUMATOID ARTHRITIS
☐ OTHER (PLEASE INCLUDE ANY FOOT OR ANKLE PROBLEMS) _____

VITALS: HEIGHT (INCHES) _____ WEIGHT (POUNDS) _____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____

SIGNATURE OF PATIENT (PARENT OR GUARDIAN IF APPLICABLE) DATE

YOU MUST READ BELOW FOR IMPORTANT INFORMATION AND NOTICES

Financial Policy

I understand that I am financially responsible for all charges for services to me, including co-payments, co-insurance, out-of-pocket, deductibles and noncovered services.
I authorize the payments from my insurance company(s) according to my medical benefits be made payable to ***Medical Associates of Brevard LLC*** for professional services rendered. I understand that I will receive statements, reflecting my account balance and that the FINAL PAYMENT of this account is my responsibility. Furthermore, should I default on payment for services rendered I agree to pay all collection costs including reasonable attorney's fee. I authorize the disclosure of my medical information to all of Medical Associates of Brevard as well as to my insurance company(s).

LIFETIME SIGNATURE AUTHORIZATION: This signature and assignment is to be a continuing one, remaining in effect until revoked in writing by the undersigned. It signifies that all information given is current.

NOTE: You will electronically sign for this Financial Policy agreement on the signature pad in your doctors' office to be stored in your electronic medical chart.

Notice of Privacy Practices

I acknowledge that I have received a copy of the **Provider Notice of Privacy Practices** for Medical Associates of Brevard LLC. The Provider Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Provider Notice of Privacy Practices also describes my right and the responsibilities of duties of Medical Associates of Brevard with respect to my protected health information.

NOTE: You will electronically sign for this Notice of Privacy Practices on the signature pad in your doctors' office to be stored in your electronic medical chart.

Consent to Obtain External Prescription History

I authorize Medical Associates of Brevard LLC and its physicians and staff to view my external prescription history via the electronic medical records system Medent, and the Surescripts service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.
MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

NOTE: You will electronically sign for this Consent to Obtain External Prescription History on the signature pad in your doctors' office to be stored in your electronic medical chart. **You will have the option to give consent or deny this access upon electronically signing.**

Community Chart Consent

I give consent to Medical Associates of Brevard LLC to access the Community Chart in order to access and share my medical records if available through other entities operating under the Carequality Interoperability Framework, including Surescripts. This includes demographic information as well as other relevant clinical documentation.

NOTE: You will electronically sign for this Community Chart Consent on the signature pad in your doctors' office to be stored in your electronic medical chart. **You will have the option to give consent or deny this access upon electronically signing.**

MEDICAL ASSOCIATES OF BREVARD

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION.

PLEASE REVIEW IT CAREFULLY

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on September 1, 2013 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

***Payment*:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

***Healthcare Operations*:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

***Disclosure*:** We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased, we may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. The Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. A fee will be charged to cover coping costs and the staff time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

***Abuse or Neglect*:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)
We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Research: We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Your Health Information Rights

Inspect and Copy. Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Coping fees as allowed by Florida Statues will apply. If you prefer a summary or an explanation of your health information, we will provide it for a fee. If you want the copies mailed to you, postage will also be charged. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Access to your health information in electronic form, if readily producible, may be obtained with your request. A fee will be charged to cover the cost of staff to produce the electronic copy and the cost of the electronic media unto which the copy is saved. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. Please contact our Privacy Officer for an explanation of our fee structure.

Request Amendment. You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

***Right to Request Restriction of PHI*:** If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

***Public Health Responsibilities*:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

***Marketing Health-Related Services*:** We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

***Sale of PHI*:** We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

***Breach Notification Requirements*:** It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS
You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

***HOW TO CONTACT US*:**

Daniel Cohen, DPM & Randi Meberg, DPM
Podiatry
Office Contact: Randi Meberg, DPM
7730 N Wickham Rd, Suite 103
Melbourne, FL 32940
Tel: (321) 253-3595 Fax: (321) 253-3596

MAB Privacy Officer: Chris Kelly
Tel: (321) 253-2900 x7 Fax: (321) 435-0100