Patient Name: _____ DOB _____

MAB PULMONARY/SLEEP MEDICINE
Dr. S. Jerry Pinto
Holly Bell, ARNP-C

Hello,

Please fill out this paperwork and brint it with you to your appointmet along with your insurance cards and a list of medications you may be taking including anything over the counter. Be sure to include any vitamins, herbs and supplements

It is essenctial if you have seen another Pulmonologist/Sleep Specialist that you bring those records with you to your appointment.

If you are unaware of your specialist co-pay/co-insurance you may want to check with your insurance company as you will be responsible for that payment when you check in.

*Due to changes in healthcare guidelines, all prescription refills and new appointment requests must be made throughyour personalized patient portal.

In order to set you up with your portal, we must have a valid email address on file.

_____@ _____

If you are currently under the care of another physician in our group (MAB), we may already have your email on file, please ask us for your log-in credentials. We'll be happy to give you a print-out at check out.

Thank you ☺

MAB
MEDICAL ASSOCIATES OF BREVARD

PATIENT INFORMATION **TODAY'S DATE** _____

Patient's Name _____
(Last) (First) (MI)

DOB ____/____/_____ Social Security # _____-_____-_____ Marital Status _____ ☐ Male ☐Female

RACE: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Black or African American ☐ White
☐ Other Pacific Islander ☐ Do Not Want to Disclose

ETHNICITY: ☐ Hispanic ☐ Non-Hispanic ☐ Do Not Wish To Disclose

PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ French ☐ Indian (includes Hindu & Tamil) ☐ Other

Address: _____
(street) (City, State) (Zip Code)

Home phone (_____)_____ Cell phone (_____)_____ Work phone (_____)_____

Email address _____ Patient's Employer _____

Name of spouse or Parent _____ Emergency contact information

Address _____ Name _____

_____ Relationship _____ Phone #: _____

Referring Physician _____ Family Doctor _____ Phone #: _____

INSURANCE INFORMATION

Primary Insurance Co. _____ Policy # _____

Name of Insured party _____ DOB: _____ SS # _____

Secondary Insurance Co. _____ Policy # _____

Name of Insured party _____ DOB: _____ SS # _____

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

SIGNED _____ Date _____/_____/_____

MAB
MEDICAL ASSOCIATES OF BREVARD

TODAY'S DATE _____

Patient's Name _____ DOB _____

REASON FOR APPOINTMENT: _____

PAST MEDICAL PROBLEMS: Please list ALL medical problems including those you are taking medications for:

_____ _____

_____ _____

_____ _____

FAMILY HISTORY

Family member	Age (if living)	Health Good	Poor	List any illnesses	If deceased Cause of death	Age of death
Father						
Mother						
Brothers or sisters						
Children						

PERSONAL HISTORY: (Women: do not list pregnancies)

Surgery/Hospitalization	Diagnosis	Date/Year

RISK FACTORS

Do you smoke? ____How much?_____ Per day

Did you smoke previously? _____

What year did you quit? _____

Do you drink alcohol? _____ How often? _____

Do you use recreational drugs? _____

When did you last have the following? (date)

Chest x-ray _____ Chest CT _____

PET/CT_____ Sleep Study_____

T.B. Skin test _____

T.B. Positive/Negative _____

Pulmonary Function Test (Date) if applicable _____/_____/_____

PRESENT MEDICATIONS

1.
2.
3.
4.
5.
6
7.
8.
9.
10.
DRUG ALLEGERGIES
1
2.
3.
4.
5.
6.

402 N. Babcock St. Suite 102, Melbourne, FL 32935 Phone: (321)241-6540 Fax: (321)428-4442

Patient Name: _____ DOB _____

MAB PULMONARY/SLEEP MEDICINE
Dr. S. Jerry Pinto
Holly Bell, ARNP-C

REVIEW OF SYSTEMS:

Place an X before sings of symptoms which you presently have or have had frequently

1. **CONTITUTIONAL**
   - _____ weight loss
   - _____ fever
   - _____ chills
   - _____ fatigue
   - _____ loss of appetite
2. **NEUROLOGICAL**
   - _____ convulsions
   - _____ loss of consciousness
   - _____ tremors
   - _____ tingling
3. **EYES**
   - _____ blurring
   - _____ sudden blindness
   - _____ double vision
4. **EARS/NOSE/THROAT**
   - _____ sinus pain
   - _____ sinus drainage
   - _____ hoarseness
   - _____ nasal polyps
5. **LYMPH/BLOOD**
   - _____ easy bruising
   - _____ frequent bleeds
   - _____ swelling in neck/underarms
6. **PULMONARY**
   - _____ wheezing
   - _____ cough, dry
   - _____ cough with phlegm
   - _____ shortness of breath w/activity
   - _____ blood in sputum
7. **SLEEP**
   - _____ difficulty falling asleep
   - _____ difficulty staying asleep
   - _____ daytime fatigue/sleepiness
   - _____ snoring

8. **CARDIOVASCULAR**
   - _____ chest pain
   - _____ palpitation
   - _____ heart murmur
   - _____ swelling of ankles/feet
9. **GASTROINTESTINAL**
   - _____ difficulty swallowing
   - _____ heartburn
   - _____ vomiting
   - _____diarrhea
10. **GENITOURINARY**
    - _____ frequent urination at night
    - _____ blood in urine
    - _____painful urination
11. **MUSCULOSKELETAL**
    - _____ joint pain
    - _____ joint swelling
    - _____ generalized muscle aches
    - _____ morning stiffness
12. **SKIN**
    - _____ rash
    - _____ ulceration
    - _____discoloration
13. **KIDNEY**
    - _____ kidney stones
    - _____ kidney disease
14. **PSYCHIATRIC**
    - _____ mood swings
    - _____ panic attacks
    - _____ depression

ANY OTHER IMPORTANT SYMPTOMS:

_____

_____

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Patient Name: _____ DOB _____

MAB PULMONARY/SLEEP MEDICINE
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HIPAA RELEASE

I authorize Medical Associates of Brevard to discuss my health care information with:

_____

(Name) (Relationship) (Phone #)

_____

(Name) (Relationship) (Phone #)

Signed _____ Date _____/____/____

I authorize Medical Associates of Brevard to leave a dated message on my answering machine.

Signed _____ Date ____/____/____

Notice of Privacy Practices

I knowledge that I have received a copy of the Provider Notice of Privacy Practices for Medical Associated of Brevard. 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 and duties of Medical Associate of Brevard with respect to my protected health information.

_____

Name of Patient or Personal Representative

_____

Signature Date

_____

Name of Witness Date

Patient Name: _____ DOB _____

MAB PULMONARY/SLEEP MEDICINE
Dr. S. Jerry Pinto
Holly Bell, ARNP-C

FINANCIAL ASSIGNMENT AND AGREEMENT

Thank you for choosing our practice. We are committed to providing the highest quality of service. Because patients often have questions regarding insurance and patient responsibility, we have elected to make a policy update which will outline the details involved in the billing process.

Patients are responsible for all co-payments, co-insurances and deductibles as outlined by their insurance. Patients are expected to pay this amount at the time of service. Please note that this arrangement is part of your contract with your insurance company and failure on our part to collect this from patients could be considered insurance fraud. Please help us comply with insurance rules by paying this amount at each visit. While we may be able to estimate what your portion will be, the final amount is determined by your insurance company.

If you do not have a valid credit card then another form of payment (e.g. check or cash) will be expected at the time of the visit. We also have payment plans available to help you with your balance if needed.

Below is a guide that will hopefully make this process easier for you to understand.

If you have:	Your responsibility:	Staff assistance:
Medicare with a secondary	No payment due unless it is determined that the secondary will not cover your co-pay/deductible in full. You are required to pay the difference.	File the claim on your behalf to Medicare and our secondary insurance.
Medicare only	You are required to pay your annual deductible and 20% co-insurance for services rendered.	File the claim on your behalf to Medicare and give you an ESTIMATE of the costs of services to be rendered
Private insurance	Payment for patient responsibility portion of all services rendered.	Assist to determine co-pay and co-insurance amounts. We will give you an ESTIMATE of the costs of services to be rendered.
HMO's and PPO's (which we are in network)	Payment for patient responsibility portion of all services rendered.	Assist to determine co-pay and co-insurance amounts. We will give you an ESTIMATE of the costs of services to be rendered
Health Savings Accounts/High deductible plans	Payment in full of services rendered unless deductible has been met – then please refer to private insurance information.	Assist to determine how much of the deductable has been met and any co-insurance due. Make payment arrangements if approved by Provider.
No insurance	Payment in full for services rendered.	Work with you to settle your account. Make payment arrangement if approved by Provider.

Name _____ Signature _____ Date: _____

Patient Name: _____ DOB _____

MAB PULMONARY/SLEEP MEDICINE
Dr. S. Jerry Pinto
Holly Bell, ARNP-C

FINANCIAL POLICY (CONTINUED)

Regarding Insurance
We participate in most major insurances. For some other insurance, we accept assignment of benefits but in all cases we require that the guarantor, the person who is financially responsible, is personally liable for all balances not covered by insurance. ***It is your responsibility to understand your insurance coverage***, and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the medical services provided may be a non-covered service or may not be considered medically necessary under the Medicare Program or by other medical insurance companies. You may also be subject to a deductible that would require you to pay for your entire visit. We do offer a cash paying discount for persons who are not covered by insurance, and these cases are decided upon by the physician.

Usual and Customary Rates
We are committed to providing the best treatment for our patients and all of Medical Associates of Brevard's providers charge what we believe to be reasonable and customary fees for our region and specialty. If your insurance company uses a different fee schedule, you will be responsible for any balance remaining.

No Show Fees
Because we want to offer appointments to all of our patients who need them, patients that fail to provide 24 hours notice before canceling their appointment are considered a NO SHOW. These NO SHOW appointments are subject to a $25 charge.

Past Due Accounts
We will attempt to work out a payment schedule with you, but seriously overdue accounts will be referred to a collection agency. Legal fees that we pay to secure past due balances will be added to your account.

Returned Checks
For checks returned to us as unpaid by your bank, we will charge a $20 fee. This fee plus the amount shown on the returned check must be paid by certified check, cash or credit card only. Future payments to our office by patients who have had a check returned will need to be made by cash or credit card only.
I have read the Financial Policy. I understand and agree to the Financial Policy.

I have read part 2 of the financial policy. I understand and agree to the financial policy.

Name _____ Signature _____ Date _____