New Patient Registration

MEDICAL ASSOCIATES OF BREVARD

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
MEDICAL ASSOCIATES OF BREVARD

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.

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.**

HEALTH HISTORY QUESTIONAIRE

MAB GASTROENTEROLOGY

NAME:Last_____**First**_____**MI**___

DOB:_____ **REFERRED BY:**_____ **TODAY'S DATE:**_____

REASON FOR APPOINTMENT:_____

MEDICATIONS: List **ALL** medications, including the dosage. Please include all over-the-counter medications, vitamins, herbs, etc.

_____

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES: List **ALL** medicine and foods, include the reaction you get.

_____

_____

_____

_____

PREVIOUS SURGERIES: Please include the dates.

_____

_____

_____

_____

_____

PREVIOUS HOSPITALIZATIONS: Please include the dates.

_____

_____

_____

_____

REVIEW OF SYSTEMS: How are you feeling today? Please check the appropriate response box.

SYMPTOM	NO	YES
HEENT		
Change in vision		
Ringing in ears		
Dry mouth		
Nose bleeds		
Sinus congestion		
Post nasal drip		
Sore throat		
SKIN		
Skin rash		
Skin cancer		
Blisters		
Bruise easily		
RESPIRATORY		
Persistent cough		
Shortness of breath		
Coughing up blood		
Wheezing		
Sleep apena		
CARDIAC		
Chest pain or discomfort		
Angina		
Wake at night short of breath		
Fainting		
Racing or skipping heartbeats		
Leg or feet swelling		
UROLOGIC		
Blood in urine		
Pain with urination		
Difficulty in stream		
Urinary incontinence		
Frequent urination		
Wake at night to urinate		

SYMPTOM	NO	YES
MUSCULOSKELETAL		
Joint pain		
Joint swelling		
Joint stiffness		
Back pain		
Sciatica		
Back stiffness		
NEUROLOGIC		
Change in thinking/confusion		
Headache		
Double vision		
Vertigo/Room spinning		
Weakness		
Seizures		
History of Stroke		
Numbness/tingling of extremities		
PSYCHOLOGIC		
Depression		
Anxiety		
Insomnia		
HEMATOLOGIC		
Easy bleeding		
Easy bruising		
Blood clots		
History of Hemophilia		
CONSTITUTIONAL		
Excessive thirst		
Cold intolerance		
Ten pounds or more recent weight gain		
Ten pounds or more recent weight loss		
Fatigue that limits your daily activities		
If female, breast feeding		
If female, pregnant		

NAME_____**DOB**_____

TODAYS DATE_____

PREVIOUS TESTS: Please include dates

_____ Colonoscopy _____ Upper G.I. series

_____ Endoscopy/EGD _____ CT Scan of Abdomen

_____ Sigmoidoscopy _____Ultrasound of Abdomen

_____Gallbladder X-Ray _____Prostate Exam &/or PSA

_____Hemoccult cards (to check for blood in stool)

PAST MEDICAL HISTORY: Please check if you or have you ever had:

CONDITION	NO	YES
Diabetes mellitus		
High blood pressure		
Heart disease		
Heart attack		
Heart murmur		
Cardiac arrhythmia		
Implanted defibrillator		
Pacemaker		
Asthma		
Tuberculosis		
Von Willebrands		
Blood transfusion		
Anemia		

CONDITION	NO	YES
Difficulty w/anesthesia		
Kidney stones		
Chronic kidney disease		
Thyroid disease		
Glaucoma		
Mouth ulcers		
Neurological disorders		
Poor balance		
Hearing loss		
Hoarseness		
Flu vaccine		
Hepatitis vaccine		
Cancer		

FAMILY HISTORY:

Check any condition that any BLOOD relative has/had and state whom.

_____Ulcers _____

_____Gallstones _____

_____Pancreatic Disease _____

_____Colon Polyps _____

_____Colon Cancer _____

_____Colitis _____

_____Liver Disease _____

_____Diabetes _____

_____ Heart Disease _____

_____ Bleeding Problems_____

_____ High Blood Pressure_____

NAME_____ **DATE OF BIRTH**_____-_____-_____

TODAY'S DATE_____-_____-_____

Family History

	Alive	Deceased	Age	Health	If deceased, cause of death
Father					
Mother					
Siblings					
Children					
Grandparents					

Do any diseases tend to run in your family? If so, please state below.

Social history:

Occupation:_____

Marital Status: Circle One: Married Widowed Divorced Single

Children:_____ How Many?_____Ages:_____

Do you exercise? No 1-3 days/week more than 3 days/week

Walk Run Bike Gym Other_____

Do you or have you ever smoked? _____No _____Yes

_____Cigarettes _____Pipe _____Cigars
_____Chew

Packs per day_____ How many years_____

Do you or have you ever consumed alcohol?

____No ____Yes If yes, how many years**?** _____

How many drinks per day? _____
How many drinks per weekend? _____
What types of alcohol do you usually drink? _____

Do you have any pets? If yes, what type? _____

What is your daily caffeine intake? (per cup – state amount)
Coffee_____ Tea_____ Soda_____ Cocoa_____ Chocolate_____

What is your dairy intake per day?
Milk_____glasses Cheese_____ounces Ice Cream_____cups Yogurt____cups
Other _____

NAME_____ DATE OF BIRTH_____-_____-_____

TODAY'S DATE_____-_____-_____

ADVANCED DIRECTIVE

MAB GASTROENTEROLOGY

All adults in health care settings have the right in the state of Florida to an *"Advanced Directive".* This is a written or oral statement made and witnessed in advance of a serious illness or injury, stating how medical decisions will be made. An *Advanced Directive* enables you to state your choice, or may name someone to make your choice for you if you should be come unable to make decisions about your medical treatment. An advanced directive can enable you to make decisions about your future medical care.

I have received information on *"Advanced Directive."*

Signature:_____ Date:_____

ADVANCED DIRECTIVES

(for compliance with the patient self-determination act)

Have you executed an *Advanced Directive*? Yes_____ No_____

If yes, is this directive in the form of:

_____ Living will

_____ Durable Power of Attorney

_____ Health Care Surrogate

If you have executed an *Advanced Directive* in any of the above formats, have you provided this office with a copy for your medical records?

_____ Yes _____ No

_____

Signature

MAB
MEDICAL ASSOCIATES OF BREVARD

A Multi-Specialty Group Practice

JOHN C. TURSE, M.D.
ADWAIT JATHAL, M.D.
BOARD CERTIFIED GASTROENTEROLOGY
AND INTERNAL MEDICINE

FINANCIAL POLICY

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

Patients are responsible for all co-payments, co-insurance and deductibles as outlined by their insurance policy. Patients will be 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 company rules by paying the amount that your are responsible for. While we will estimate what your insurance will pay, the final amount is determined by your insurance company.

We require all patients to submit a valid credit card at the time of their visit that will be kept on file to charge any copayments/coinsurance and or deductibles as determined by the EOB (explanation of benefits) from your insurance company.

If you do not have a credit card or choose not to provide one, then another form of payment (E.g. check or cash) will be expected at the time of the visit.

Please note, your visit may be cancelled if you do not submit the required payments.

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

If you have	Your responsibility	Staff assistance
Medicare With secondary insurance:	No payment is due *unless* it is determined that the secondary insurance will not cover your co-insurance or deductible in full. You are required to pay the difference.	File the claim on your behalf to Medicare and secondary insurance
Medicare Without secondary insurance:	You are required to pay the 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.	Call insurance company to determine co-pay and co-insurance amounts. We will give you an ESTIMATE of the costs of services to be rendered.
HMOs and PPOs With which we are in network:	Payment for patient responsibility portion of all services rendered.	Call insurance company 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 for services rendered unless deductible has been met; then please refer to private insurance information.	Call insurance company to determine how much of the deductible amount has been met and any co-insurance due.
No Insurance:	Payment in full for services rendered.	Work with you to settle your account.

NO SHOW POLICY: If you no-show for a scheduled appointment without prior notification, you will be charged $50.00. If you schedule a procedure and no-show without prior notification, there will be a $100.00 charge.

Name_____Signature_____Date:_____

200 Michigan Avenue • Melbourne, Florida 32901 • (321) 952-0700 • Fax (321) 952-4444

MAB GASTROENTEROLOGY
JOHN C. TURSE, M.D.
ADWAIT JATHAL, M.D.
321-952-0700

Today's Date: _____

Patient:_____ DOB:_____

Credit Card Authorization Form

I authorize MAB GI to charge my credit card for the portion of my health care costs as determined by my insurance company. This will be charged upon MAB-GI's receipt of my Explanation of Benefits (EOB).

Charge to: **Visa** **Mastercard** **American Express** **Discover** **Debit Card**

Name as it appears on card: _____

Credit card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Exp. Date:_____ Sec Code:_____

Billing Address of Cardholder: _____

City:_____ St:_____Zip:_____

Signature of cardholder: _____

OFFICE USE ONLY

Procedure to be scheduled: ____Colonoscopy ____EGD ____ Other _____

Date of Procedure: _____

The estimated cost of the procedure(s) is $_____

Method of payment: _____ Cash_____ Check _____Credit Card

Amount paid today $_____