



Welcome to The Brevard Health Alliance

The Brevard Health Alliance, Inc. (BHA) is a Community Health Center serving Brevard County residents providing comprehensive medical services to all residents. It is the mission of The Brevard Health Alliance, Inc. to improve the health status through a **medical home model**, providing comprehensive medical, behavioral health, and dental care to the children and adults in our community. The Brevard Health Alliance, Inc. offers a sliding fee scale, which allows uninsured patients to take advantage of a discount on services. BHA is excited that you chose us as your **medical home**.

If you have any questions or concerns in reference to your care, please feel free to contact your Medical Team at the phone number listed below during business hours.

BHA maintains providers on call after hours and on weekends to evaluate urgent situations by phone. Please call (321) 951-8463 to access our on-call provider.

<input type="checkbox"/> <u>BHA Palm Bay Clinic</u> 5270 Babcock St NE Ste #1 Palm Bay, FL 32905 (321) 722-5959 Phone (321) 722-5960 Fax Hours: Mon-Th 8-7; Fri 8-5	<input type="checkbox"/> <u>BHA Malabar Clinic</u> 775 Malabar Rd #105 Malabar, FL 32950 (321) 722-8435 Phone (321) 733-0644 Fax Hours: Mon-Thur 8-7; Fri 8-5 (Family Practice) Mon-Fri 8-6 (Pediatrics)	<input type="checkbox"/> <u>BHA Melbourne Clinic</u> 17 Silver Palm Avenue Melbourne, FL 32901 (321) 733-2021 Phone (321) 727-0884 Fax Hours: Mon-Th 8-7; Fri 8-5
<input type="checkbox"/> <u>BHA Rockledge Clinic</u> 220 Barton Blvd. Rockledge, FL 32955 (321) 639-5177 Phone (321) 639-4927 Fax Hours: Mon-Th 8-7; Fri 8-5	<input type="checkbox"/> <u>BHA Sarno Clinic</u> 2120 Sarno Road Melbourne, FL 32935 (321) 241-6800 Phone (321) 241-6888 Fax Hours: Mon-Thu 8-7; Fri 8-5	<input type="checkbox"/> <u>BHA Titusville Clinic</u> 500 N Washington Ave #105 Titusville, FL 32796 (321) 268-0267 Phone (321) 268-3357 Fax Hours: Mon-Th 8-7; Fri 8-5
<input type="checkbox"/> <u>BHA Port St. John Clinic</u> 7227 N. Highway 1 Cocoa, FL 32927 (321) 877-2740 Phone (321) 877-2793 Fax Hours: Mon- Fri 8-5	<input type="checkbox"/> <u>BHA Mobile Clinic</u> **Refer to www.bhachc.org for locations and times** (321) 914-5864 Mobile 1 Phone (321) 914-5033 Mobile 2 Phone	

Please call for Saturday Dates/Times

www.bhachc.org

We look forward to meeting all your healthcare needs!

New Patient Registration Form

Please Bring Photo ID, Social Security Card, and Insurance Card

DO YOU NEED ASSISTANCE WITH COMMUNICATION? Yes No

If YES, please explain: _____

Patient's Name: _____

	Last	First	Middle Initial
Mother/Legal Guardian's Name: _____	_____	_____	_____
<i>(If patient is a minor)</i>	Last	First	Middle Initial

Can Dad bring minor in for visit? Yes No
(If yes, fill out line below)

Can Mom bring minor in for visit? Yes No
(If yes, fill out line above)

	Last	First	Middle Initial	Mother/Guardian's SSN
Father/Legal Guardian's Name: _____	_____	_____	_____	_____
<i>(If patient is a minor)</i>	Last	First	Middle Initial	Father/Guardian's SSN

Patient Address: _____

Street Address	City	State	Zip Code
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Email Address: _____

Home Phone: _____ - - Cell Phone: _____ - - Work Phone: _____ - -

Patient's Social Security: _____ - - Patient's Date of Birth (mo/day/yr): ____ / ____ / ____

Patient's Gender Identity: Male Transgender Male/Female-to-Male Other
 Female Transgender Female/Male-to-Female Choose not to disclose

Marital Status: Single Married Divorced Widowed

Race: American Indian/Alaskan Native Native Hawaiian Asian Non-Hispanic White
 Black/African American Other Pacific Islander Unreported Hispanic
 More Than One Race Other: _____

Patient's Sexual Orientation: Straight or heterosexual Bisexual Don't know
 Lesbian, gay or homosexual Something else Choose not to disclose

Housing Status: Own Rent Public Housing Section 8 Other: _____

If OTHER, please identify Homeless Status:

Transitional Housing Homeless Shelter Street Doubled Up Other: _____

Served in U.S. Armed Forces: Yes No

Employment Status:

<input type="checkbox"/> Employed (Part time/Full time)	<input type="checkbox"/> Self-Employed	<input type="checkbox"/> Not Employed
<input type="checkbox"/> Disabled	<input type="checkbox"/> Retired	<input type="checkbox"/> Student (Part time/Full Time)

Patient's Employer Information: _____

Name	Phone Number
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Emergency Contact: _____

Name	Phone Number	Relationship
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Patient Classification:

- Without insurance and requesting Sliding-Fee Scale
- Without insurance **NOT** requesting Sliding-Fee Scale
- With insurance and requesting Sliding-Fee Scale
- With insurance **NOT** requesting Sliding-Fee Scale *(If you lose your insurance you will not automatically be enrolled in our Sliding-Fee Scale)*

I declare the information on this form to be true and correct and agree to the verification of this information by BHA. I authorize BHA to release any information to any insurance company or any Federal or State agency that may be involved in the providing insurance I have designated. I promise that, in consideration for the treatment of me or my children, or any party for whom I am guarantor, I will pay for or assign payment for the charges for that treatment to BHA.

Signature: _____ Date: ____ / ____ / ____ Relationship: Self Other: _____

FINANCIAL DETERMINATION WORKSHEET

Patient Name: _____ Patient Date of Birth (mo/day/yr): _____ / _____ / _____

Insurance Information

Do you currently have insurance? Yes No

Insurance Company: _____
 Subscriber No.: _____ Group No.: _____
 Policyholder's Name: _____ Birthdate: _____ / _____ / _____ Policyholder's SSN: _____ - _____ - _____
 Policyholder's mailing address: _____ City: _____ State: _____ Zip: _____
 Phone: _____

Please bring the following when coming in to register for the Sliding-Fee Scale:

1. Picture ID – or other proof to confirm Brevard County residency.
2. Social Security Card – if possible.
3. Proof of gross monthly income – for the last 2 months for all related household members, such as:
 - Paycheck stubs
 - Social Security Income
 - Bank Statements
 - W2 Statements
4. Federal Income Tax Return – the patient's most recently filed Return is required to apply for assistance with medications.

HOUSEHOLD INCOME AMOUNT AND FREQUENCY	SOURCE OF HOUSEHOLD INCOME (check all that apply)
Hourly: \$ _____ x 2080 = \$ _____	<input type="checkbox"/> Employment \$ _____/month
Weekly: \$ _____ x 52 = \$ _____	<input type="checkbox"/> AFDC \$ _____/month
Monthly: \$ _____ x 12 = \$ _____	<input type="checkbox"/> Social Sec. \$ _____/month
Other: \$ _____ x _____ = \$ _____	<input type="checkbox"/> SSI \$ _____/month
	<input type="checkbox"/> Child Support \$ _____/month
	<input type="checkbox"/> Other \$ _____/month

RESIDENCE: OWN RENT OTHER: _____

NUMBER OF RELATIVES IN HOUSEHOLD: _____

NAME: _____ AGE: _____ RELATIONSHIP: _____
 NAME: _____ AGE: _____ RELATIONSHIP: _____
 NAME: _____ AGE: _____ RELATIONSHIP: _____
 NAME: _____ AGE: _____ RELATIONSHIP: _____

Proof of Income: YES NO (Please check all that apply)
 Tax Return Wage Statement SS Statement Bank Statement Other: _____

I, _____, have a household income of \$ _____,
 every Week, Month, Year, but attest that I am unable to provide proof of that income.

I attest that I have provided complete and accurate information regarding all of my household income and assets.

Patient or Parent/Guardian: _____
Signature Date

Witness: _____
Brevard Health Alliance Representative Date

****Fees start at \$10 for a Medical Visit on the Sliding-Fee Scale****

Patient Consents and Acknowledgements

	Initial									
<p>1. Consent for Treatment (Self)</p> <p>I authorize the health care providers of The Brevard Health Alliance (BHA) to treat, prescribe medications and consent to photograph for purposes of treatment and accurate identification for me, as the providers feel necessary.</p>										
<p>2. Consent for Treatment of another Patient/Minor (Not Self)</p> <p>I, as the parent or legal guardian/representative of the patient, do hereby give my consent and authorize treatment. Furthermore, the named individuals below may, if I am not present, in accordance with the consent communicated by the above individual to Physicians pursuant to the delegation of my authority granted here, and consistent with the Providers' professional judgment of my Child's medical needs, authorize Providers to see, examine, evaluate and treat (including immunizations, minor procedures and/or lab work). This authorization will remain in effect until revoked by me in writing.</p> <p><u>Authorized Persons to Consent for Treatment of another Patient/Minor:</u></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 33%; text-align: center;">Name (Print)</td> <td style="border-bottom: 1px solid black; width: 33%; text-align: center;">Phone No.</td> <td style="border-bottom: 1px solid black; width: 33%; text-align: center;">Relationship</td> </tr> <tr> <td style="border-bottom: 1px solid black; text-align: center;">Name (Print)</td> <td style="border-bottom: 1px solid black; text-align: center;">Phone No.</td> <td style="border-bottom: 1px solid black; text-align: center;">Relationship</td> </tr> <tr> <td style="border-bottom: 1px solid black; text-align: center;">Name (Print)</td> <td style="border-bottom: 1px solid black; text-align: center;">Phone No.</td> <td style="border-bottom: 1px solid black; text-align: center;">Relationship</td> </tr> </table>	Name (Print)	Phone No.	Relationship	Name (Print)	Phone No.	Relationship	Name (Print)	Phone No.	Relationship	
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<p>3. Students Working Onsite</p> <p>I understand that The Brevard Health Alliance supports the education of medical professionals and maintains students that may assist in relation to care.</p>										
<p>4. Notice of Privacy Practices</p> <p>I acknowledge I may receive the practice's Notice of Privacy Summary upon request, which describes the ways in which the practice may use and disclose my healthcare information for its treatment and payment/healthcare operations and other described and permitted uses and disclosures. I understand I may contact the Compliance Officer if I have a question or complaint. To the extent permitted by the law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy.</p>										
<p>5. HIE Consent</p> <p>The Health First Health Information Exchange (HIE) grants clinicians participating in your care electronic access to your most up to date medical records. This consent is to establish if you would like to participate in the Health First HIE.</p> <p><input type="checkbox"/> Opt in <input type="checkbox"/> Opt out</p> <p>This authorization will remain in effect until revoked by me in writing.</p>										
<p>6. Patient Rights and Responsibilities</p> <p>I acknowledge I may receive a copy of my rights and responsibilities upon request, and I fully understand all of my rights and responsibilities and agree to comply with the requirements of BHA.</p>										
<p>7. After-Hours and Emergency Care</p> <p>I acknowledge I have received a copy of the hours of operation for each clinic and the after-hours phone number for The Brevard Health Alliance, Inc. to reach an on-call provider in a medical emergency.</p>										

<p>8. HIPAA Consent</p> <p>We are unable to give out confidential patient information to any party over the telephone or in person without your written authorization. If you wish us to discuss your personal medical information over the telephone or in person with someone other than yourself, we ask that you complete the authorization below.</p> <p>I authorize Brevard Health Alliance to release my protected health information (PHI) to the authorized person or persons listed below. This may include information relating to sexually transmitted diseases (STDs), acquired immunodeficiency syndrome (AIDS), and infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services and treatment for drug or alcohol abuse.</p> <table style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="border-top: 1px solid black; width: 33%; padding: 5px;">Name (Print)</td> <td style="border-top: 1px solid black; width: 33%; padding: 5px;">Phone No.</td> <td style="border-top: 1px solid black; width: 33%; padding: 5px;">Relationship</td> </tr> <tr> <td style="border-top: 1px solid black; padding: 5px;">Name (Print)</td> <td style="border-top: 1px solid black; padding: 5px;">Phone No.</td> <td style="border-top: 1px solid black; padding: 5px;">Relationship</td> </tr> <tr> <td style="border-top: 1px solid black; padding: 5px;">Name (Print)</td> <td style="border-top: 1px solid black; padding: 5px;">Phone No.</td> <td style="border-top: 1px solid black; padding: 5px;">Relationship</td> </tr> </table>	Name (Print)	Phone No.	Relationship	Name (Print)	Phone No.	Relationship	Name (Print)	Phone No.	Relationship	
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<p>9. Patient Bill of Rights</p> <p>The Patient Bill of Rights is posted in the lobby. I acknowledge I may receive a copy of the Patient Bill of Rights upon request.</p>										
<p>10. Notice of Policy regarding Advanced Directives <i>(for patients over 18 years of age)</i></p> <p>Advanced Directives are legal statements that indicate the type of medical treatment wanted or not wanted in the event an individual is unable to make decisions as well as who is authorized to make them. Advanced Directives are made and witnessed prior to serious injury.</p> <p>In accordance with federal and state law, this serves as notification that we will set aside your Advanced Directive in the event you experience a life threatening event while at one of the Brevard Health Alliance locations and you will be transferred to a higher level of care.</p> <p>By signing below, you agree and understand this as notification. Please indicate below whether or not you have an Advanced Directive.</p> <p><input type="checkbox"/> I have an Advanced Directive. <input type="checkbox"/> I do not have an Advanced Directive.</p>										
<p>11. Patient-Centered Medical Home</p> <p>I acknowledge that I have received information about The Brevard Health Alliance, Inc. medical home model, and acknowledge that I understand BHA is my patient-centered medical home.</p>										
<p>12. Electronic Messaging</p> <p>I understand that I may receive messages from The Brevard Health Alliance via phone, text, and email. If you would like to opt out at any time, please alert a BHA staff member. Standard text and data rates may apply.</p>										

Patient: _____
Name (Print)

Date: ____ / ____ / ____

Parent or Guardian: _____
(if a minor) Name (Print)

Date: ____ / ____ / ____

Patient/Guardian: _____
Signature

BHA Witness: _____
Signature Date

Authorization for Release of Medical Information

1. Select a Clinic Location *(please check one)*:

- 5270 Babcock Street NE, Suite 1, Palm Bay, FL 32905.....(Tel): 321-722-5959.....(Fax): 321-722-5960
- 775 Malabar Road, Suite 105, Malabar, FL 32950..... (Tel): 321-722-8435.....(Fax): 321-722-8486
- 17 Silver Palm Avenue, Melbourne, FL 32901.....(Tel): 321-733-2021.....(Fax): 321-727-0884
- 220 Barton Blvd, Rockledge, FL 32955.....(Tel): 321-639-5177.....(Fax): 321-639-4927
- 500 N. Washington Avenue, Suite 105, Titusville, FL 32796.....(Tel): 321-268-0267.....(Fax): 321-268-3357
- 2120 Sarno Road, Melbourne, FL, 32935.....(Tel): 321-241-6800.....(Fax): 321-241-6888
- 7227 N. Highway 1, Cocoa, FL, 32927.....(Tel): 321-877-2740.....(Fax): 321-877-2793
- BHA Mobile Clinic(Tel): 321-914-5864.....(Tel): 321-914-5033

2. Patient Name *(print)* _____ Date of Birth *(mo/day/yr)* _____

Social Security #: _____

3. I Hereby Authorize Brevard Health Alliance *(check one)*:

- To Send To: To Receive From:

Name of Provider, Facility, or Person

Street Address, Suite #, Apt #

City, State, Zip Code

Phone Number

Fax Number

4. The Following Information **(SIGN YOUR INITIALS)**:

- | | |
|--|--|
| <p>_____ All Medical Information and Reports</p> <p>_____ Office Visit Reports</p> <p>_____ Immunizations & Growth Charts</p> <p>_____ X-Ray/Imaging Reports</p> <p>_____ (STD) Sexually Transmitted Diseases, and (AIDS) Acquired Immunodeficiency Syndrome, and (HIV) Human Immunodeficiency Virus</p> | <p>_____ Laboratory Reports</p> <p>_____ Drug and Alcohol Abuse</p> <p>_____ Behavioral and Mental Health Services</p> |
|--|--|

5. Dates of Service: *(From)* _____ *(To)* _____

6. This authorization will expire in one year from the date signed. Brevard Health Alliance is authorized to use outside vendors for the purpose of copying and providing the information requested. I hereby release Brevard Health Alliance, its employees, vendors, and/or independent contractors from any and all liability that may arise from the release of this information as I have directed.
7. I understand that Brevard Health Alliance does not release medical records received from other physicians, facilities hospitals or emergency rooms. You must request these parties to send your medical records where you want them to go.
8. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to Brevard Health Alliance.
9. I understand that the revocation will not apply to any information that has already been released in response to this authorization.
10. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to context a claim under my policy.

11. _____ Date _____
Signature of Client of Legal Representative

Legal Representative's Relationship to Client Date

12. ***(Use this space only if client withdraws consent)*** _____ Date Consent revoked by Client
Signature of Client or Legal Representative