Existing Patient Requalification Form

Patient's Name: ____
Last First

Mother/Legal Guardian's Name: ____________________ Last First Middle Initial
(If patient is a minor)
___ - __ - ____ Mother/Guardian's SSN

Father/Legal Guardian's Name: ____________________ Last First Middle Initial
(If patient is a minor)
___ - __ - ____ Father/Guardian's SSN

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)

Patient's Date of Birth *(mo/day/yr)*: ____ / ____ / ____

Patient Address: ____
Street Address City State Zip Code

Email Address: ____

☐ Home Phone: ___ - ___ - ____ ☐ Cell Phone: ___ - ___ - ____ ☐ Work Phone: ___ - ___ - ____

As an existing patient of The Brevard Health Alliance, I attest that the following areas need to be updated from my previous registration: (Please check all that have changed and provide details on the back of this page)

- ☐ Marital status
- ☐ Emergency contact name, contact phone number, and relationship
- ☐ Insurance status (uninsured, type of insurance, etc.)
- ☐ My "Household Income" or number of members in my "Household"
- ☐ I have previously been provided a "Health Information Exchange" authorization but I wish to change that authorization
- ☐ I have previously been provided a "Consent for Treatment (self)" or "Consent for Treatment of a Patient (not self)" authorization but I wish to change that authorization
- ☐ I have previously been provided a "HIPAA" authorization but I wish to change that authorization
- ☐ I have previously been offered a "Notice of Privacy Practices – Summary" but I would like more information
- ☐ I completed an Advanced Directives authorization but I wish to update that authorization
- ☐ I have been provided with a description of BHA's Medical Home Model but I would like more information

This signature represents an official attestation to the accuracy of the changes as noted above and that all other unchecked items remain accurate as per the previous registration. Any of these material items can be updated at any time with the Registration Department.

______________________________ ______________
Patient or Guardian Signature Date

______________________________ ______________
BHA Representative Date

BrevardHEALTHAlliance
INCORPORATED

Please check and complete the items that require an update:

☐ My Marital status has changed and is now: ____

If your name has changed, you will be asked to provide your new Social Security Card and Identification

☐ My "Emergency contact" information has changed and is now:

Name	Phone Number	Relationship to Patient

☐ My health insurance status has changed to:

- Without insurance and requesting Sliding-Fee Scale (please provide financials below)
- Without insurance **NOT** requesting Sliding-Fee Scale
- With insurance and requesting Sliding-Fee Scale (please provide financials below)
- With insurance **NOT** requesting Sliding-Fee Scale *(If you lose your insurance you will not automatically be enrolled in our Sliding-Fee Scale)* (please provide a copy of your new insurance card)

☐ My Household income has changed and is now:
(*Please provide supporting information for income change if possible.)*

HOUSEHOLD INCOME AMOUNT AND FREQUENCY	**For BHA Staff Use Only**
Hourly: $ ______ x 2080 = $ _________ Weekly: $ ______ x 52 = $ _________ Monthly: $ ______ x 12 = $ _________ Other: $ ______ x = $ _________	New SFS Determination based on new financials given or attestation: ____________________

☐ The number of members in my household is now: ____

☐ I now have other income such as Unemployment, AFDC, SSI, Child Support, Social Security, etc. in the amount of :

SOURCE OF HOUSEHOLD INCOME (check all that apply)	
☐ Employment	$ ________________/month
☐ AFDC	$ ________________/month
☐ Social Sec.	$ ________________/month
☐ SSI	$ ________________/month
☐ Child Support	$ ________________/month
☐ Other	$ ________________/month

☐ I wish to change my election for Health Information Exchange Consent, Consent for Treatment for Self or other Patient, HIPAA Form, or Advanced Directive status. (A new form will be provided to you)

☐ I wish to receive more information about BHA's Notice of Privacy Summary or the Medical Home Model. (A handout will be given to you)

This signature represents an official attestation to the accuracy of the changes as noted above.

______________________________________ ____________________
Patient or Guardian Signature Date

______________________________________ ____________________
BHA Representative Date