Welcome to Brevard Health Alliance

We are excited you have chosen BHA to be your **medical home**! Brevard Health Alliance (BHA) is a Community Health Center providing services through a **medical home model**, including comprehensive medical, behavioral health, and dental care to the children and adults in our community. BHA offers a sliding fee scale, which allows uninsured patients to take advantage of a discount on services.

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.

We are currently accepting walk-in registrations Monday through Friday 8:00am-5:00pm at any of our clinics throughout Brevard. You can find a list of our clinics and information about our services at **www.bhachc.org**. You may also register by phone with the Registration Counselor, by selecting "Registration" or "New Patient" when calling the number below.

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.

We look forward to meeting all your healthcare needs!

☐ **BHA Palm Bay Clinic** 5270 Babcock St NE Ste #1 Palm Bay, FL 32905 (321) 722-5959 Phone (321) 722-5960 Fax **Hours**: *Mon-Fri 8-5; Sat 8-1 (Family Practice) Mon-Fri 8-5;*	☐ **BHA Malabar Clinic** 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)*	☐ **BHA Melbourne Clinic** 17 Silver Palm Avenue Melbourne, FL 32901 (321) 733-2021 Phone (321) 727-0884 Fax **Hours**: *Mon-Thur 8-6; Fri 8-5;(Family Practice)*
☐ **BHA Rockledge Clinic** 220 Barton Blvd. Rockledge, FL 32955 (321) 639-5177 Phone (321) 639-4927 Fax **Hours**: *Mon-Fri 8-5 (Family Practice) Mon-Thur 8-6; Fri 8-5 (Pediatrics) Mon-Fri 8-5 (Dental)*	☐ **BHA Sarno Clinic** 2120 Sarno Road Melbourne, FL 32935 (321) 241-6800 Phone (321) 241-6888 Fax **Hours**: *Mon-Thur 8-6; Fri 8-5 (Family Practice) Mon-Thur 8-6; Fri 8-5 (Pediatrics) Mon-Thur 8-6; Fri 8-5 (Dental)* Mon-Fri 8-5 (Women's Health) 321-425-4807 Phone | 321-241-6891 Fax	☐ **BHA Port St. John Clinic** 7227 N. Highway 1 Cocoa, FL 32927 (321) 877-2740 Phone (321) 877-2793 Fax **Hours**: *Mon-Thur 8-6; Fri 8-5; (Family Practice) Mon-Fri 8-5; (Pediatrics) Mon-Fri 8-5 (Dental)*
☐ **BHA Titusville Clinic** 500 N Washington Ave #105 Titusville, FL 32796 (321) 268-0267 Phone (321) 268-3357 Fax **Hours**: *Mon-Thur 8-6; Fri 8-5 (Family Practice) Mon-Fri 8-5 (Pediatrics)*	☐ **BHA Mobile Clinic** **Refer to www.bhachc.org for locations and times** (321) 914-5864 Mobile 1 Phone	☐ **BHA Evan's Center Clinic** 1361 Florida Ave NE Ste 2 Palm Bay, FL 32905 321-241-6800 Phone 321-639-4927 Fax **Hours:** Mon/Th/Fri 8-5 (Family Practice)

Brevard HEALTH Alliance INCORPORATED

New Patient Registration Form

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

DO YOU NEED ASSISTANCE WITH COMMUNICATION? ☐ Yes ☐ No If Yes, Explain:_____

Patient's Name:_____
Last First Middle Initial

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

Father/Legal Guardian's Name:_____ - -
(If patient is a minor) Last First Middle Initial 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 Address:_____
Street Address City State Zip Code

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:

☐ Employed (Part time/Full time) ☐ Self-Employed ☐ Not Employed
☐ Disabled ☐ Retired ☐ Student (Part time/Full Time)

Patient's Employer Information:_____
Name Phone Number

Emergency Contact:_____
Name Phone Number Relationship

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 – if possible.
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 = $ _____	☐ Employment	$_____/month
Weekly: $__ x 52 = $ _____	☐ AFDC	$_____/month
Monthly: $__ x 12 = $ _____	☐ Social Sec.	$_____/month
Other: $ x = $ _____	☐ SSI	$_____/month
	☐ Child Support	$_____/month
	☐ Other	$_____/month

RESIDENCE: ☐ OWN ☐ RENT ☐ OTHER: _____

NUMBER OF DEPENDENTS 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 and understand I am responsible for submitting proof of income upon my next visit

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
1. Consent for Treatment (Self) 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.	
2. Consent for Treatment of another Patient/Minor (Not Self) 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. **Authorized Persons to Consent for Treatment of another Patient/Minor:** Name (Print) Phone No. Relationship Name (Print) Phone No. Relationship Name (Print) Phone No. Relationship	
3. Students Working Onsite I understand that The Brevard Health Alliance supports the education of medical professionals and maintains students that may assist in relation to care.	
4. Notice of Privacy Practices 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.	
5. HIE Consent 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. ☐ Opt in ☐ Opt out This authorization will remain in effect until revoked by me in writing.	
6. Patient Rights and Responsibilities 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.	
7. After-Hours and Emergency Care 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.	

8. HIPAA Consent

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 of in person with someone other than yourself, we ask that you complete the authorization below.

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.

Name (Print)	Phone No.	Relationship
Name (Print)	Phone No.	Relationship
Name (Print)	Phone No.	Relationship

9. Patient Bill of Rights

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.

10. Notice of Policy regarding Advanced Directives *(for patients over 18 years of age)*

Advanced Directives are legal statements that indicate the type of medical treatment wanted of 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.

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.

By signing below, you agree and understand this as notification.
Please indicate below whether or not you have an Advanced Directive.

- ☐ I have an Advanced Directive.
- ☐ I do not have an Advanced Directive.

11. Patient-Centered Medical Home

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.

12. FTCA Designation

Brevard Health Alliance is an FTCA Deemed Facility. This health center receives HHS funding and has Federal Public Health Service (PHS) deemed status under 42 U.S.C. 233(g)-(n). With respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals. I understand this, and may request additional information upon request.

Patient:_____ Date:____/____/____
Name (Print)

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

Patient/Guardian:_____ BHA Witness:_____
Signature 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
   - ☐ 2120 Sarno Road, Melbourne, FL, 32935 Ste 2 (Women's Health)..... (Tel): 321-425-4807..... (Fax): 321-241-6891
   - ☐ 1361 Florida Ave NE Palm Bay, FL, 32905..... (Tel): 321-241-6800..... (Fax): 321-639-4927

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)***:

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

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. _____ _____
    Signature of Client of Legal Representative Date

    _____ _____
    Legal Representative's Relationship to Client Date

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