Existing Patient Requalification Form

Patient's Name: _____
Last First

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

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

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

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: - -

Which Pharmacy do you prefer your prescriptions filled?
□ BHA Sarno Pharmacy, 2120 Sarno Rd, Melbourne FL, 32935
□ BHA Palm Bay Pharmacy, 5270 Babcock St NE, Palm Bay FL, 32905
□ BHA Barton/Rockledge Pharmacy, 220 Barton Blvd, Rockledge FL, 32955
□ BHA Titusville Pharmacy, 1537 N. Singleton Ave., Titusville FL, 32796
□ Other/Alternate Pharmacy (name & location):_____

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

Patient's Sexual Orientation:

□ Straight or heterosexual □ Lesbian, gay or homosexual □Something else □ Bisexual □ Don't know □ Choose not to disclose

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.)
- ☐ 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
- ☐ I have been provided with a description of my rights and responsibilities as a patient, 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

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)

☐ All patients placed, or wishing to be place on the Sliding Fee Scale must update household income and family size annually:
(*Please provide supporting information for income and family size.*

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
_____	_____