Brevard Health Center

Gobivenkata Balaji, MD, MBA, FACP
Monique Gilbert, PA-C
Niroj Alsuleivani, PA-C

Dear Patient:

Welcome to Brevard Health Center. I am honored that you have chosen me as your health care provider and my health care team. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.

We have enclosed a prepaid envelope for you to mail your new patient packet back to the office prior to your appointment so that all the medical information will be entered prior to your arrival. You may also drop off your packet to the front desk prior to your appointment.

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 15 minutes late. We will strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

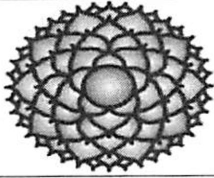
Providing the highest quality of professional care to our patients is very important to us. Therefore, the following guidelines for dispensing medications in our office have been established:

Please bring a list of your prescriptions and/or the actual medications with you to each visit.

Brevard Health Center does not offer pain management and will not dispense pain medication. We will provide you with a referral to a pain management center if you need this specialized form of care after evaluation by our physicians. If you are on a medication that requires refills for a chronic disease (for example, high blood pressure or diabetes), you will be given ample refills for 30 or 90 days at a time during your office visit. Please call your pharmacy for any refills that you may need. For the safety and well-being of our patients, requests for new medications (including antibiotics) will require an appointment.

Welcome to our practice and thank you for choosing Brevard Health Center for all your health care needs.

298 Michigan Ave, Ste. 101, Melbourne, FL 32901 Phone (321) 215 6899 Fax: (321) 215 6789



Brevard Health Center

LAST NAME:______________________ FIRST:______________________ MI:________

ADDRESS:______________________________ CITY:______________ STATE:_____ ZIP:______

HOME PH#______________ WORK PH#______________ CELL PH#______________

EMAIL ADDRESS:______________________________ REFERRING PHYSICIAN:__________

MALE:____ FEMALE:_____ AGE:_____ DATE OF BIRTH:__________ SSN:______________

MARITAL STATUS: (please circle) Child Married Single Widowed Separated Divorced

LIVING WILL: __YES __NO POWER OF ATTORNEY __YES __NO EMPLOYMENT STATUS: __EMPLOYED _RETIRED__DISABILITY__UNEMPLOYED

Responsible Party Information

LAST NAME:______________ FIRST:__________ MI:_______ RELATIONSHIP:__________

ADDRESS:____

CITY:__________________ STATE:_____ ZIP:______________TELEPHONE #:________

Insurance Information

PRIMARY INSURANCE CARRIER:________________ PRIMARY ID #:________________________

GROUP #:____________ Telephone #:________________ Are you the primary card holder? __ Yes__ No

SECONDARY INSURANCE:______________________ SECONDARY ID #______________________

GROUP #:____________ Telephone #:________________ Are you the primary card holder? __ Yes__ No

Emergency Contact Information

NAME:______________________ RELATIONSHIP:____________ TELEPHONE #____________

Pharmacy Information

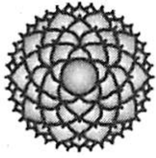
PHARMACY NAME:______________ LOCATION:________________ TELEPHONE #__________

Meaningful Use- required by the Government
Race: (please circle appropriate response) Asian- Black- Hispanic- White- Refuse – Other:______
Ethnicity: (please circle appropriate response) Hispanic – Not Hispanic – Refuse
Language: (please circle appropriate response) English- Spanish- Indian(Hindu etc) -Other: _______

On the Job Injury: ___ Yes ___No Auto Injury: ___Yes ___No Date of Accident:________ Description of Accident:__________________

I certify that the information given by me in applying for payment under my insurance contract (including Title XVII of the Social Security Act) is correct. I authorize release to my insurance carrier, referring physicians and the respective agents, and to agents of my treating physicians, and information needed including diagnosis and records of any treatment or examination rendered to me to process this claim or for purposes of care and treatment, quality assurance or utilization review. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to Brevard Health Center, PL to submit a claim to my insurance carrier, including Medicare for payment to me. I understand that is due on the day of service and I will receive itemized statements of my account reflecting the balance pending with insurance due from me. I accept the responsibility for final payment on my account regardless of the payment or lack of payment by my insurances carrier. I accept arrangements while continuing to receive care and services by Brevard Health center Pl.

PATIENT SIGNATURE:______________________________DATE:__________________



Brevard Health Center

DATE: ____________

NAME: ______________________________ AGE: _____ DOB: ____________

SEX: ___MALE___FEMALE___ REFERRED BY: ____________________ EMAIL ADDRESS: ____________________

NEXT OF KIN: ____________________ EMERGENCY CONTACT: ____________________ PH# ____________

CURRENT COMPLAINT: ______________________________

PAST MEDICAL HISTORY:

MAJOR CHILDHOOD ILLNESS	AGE	MEDICAL ALLERGIES	REACTION

ADULT MEDICAL ILLNESS	DATE	CURRENT MEDICATIONS	DOSAGE

PREVIOUS SURGERIES		DATE	

SOCIAL HISTORY: MARITAL STATUS: ____________

CHILDREN	AGE

EDUCATION: ____________

OCCUPATION: ____________

CIGARETTES: QTY: ________ HOW LONG? ________

PIPE/CIGAR: QTY: ________ HOW LONG? ________

CHEWING: QTY: ________ HOW LONG? ___ _____

PLACE AN "X" NEXT TO THE TEST YOU HAVE HAD AND GIVE THE DATE

CHEST XRAY _____ ______

ELECTROCARDIOGRAM ______ _____

PNEUMONIA VACCINE ______ _____

COLONOSCOPY ______ ________

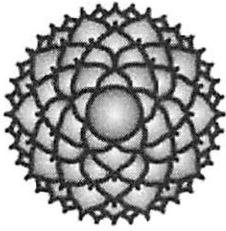
EYE EXAM DIABETES _____ _____

MAMMOGRAM ______ ______

PAP SMEAR _____ ______

COVID VACCINE ______ _____

FAMILY HISTORY:	***Alive***	***Major Illness***
FATHER:		
MOTHER:		
BROTHER:		
BROTHER:		
SISTER:		
SISTER:		
CHILDREN:		



MEDICAL INFORMATION RELEASE FORM

(**HIPAA** RELEASE FORM)

NAME: ______________________________ DATE OF BIRTH: _____/_______/_______

RELEASE OF INFORMATION

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claim information. This information may be released to:

[ ] Spouse: ______________________________

[ ] Child (ren):______________________________

[ ] Other: ______________________________

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

MESSAGES

Please call [ ] my home [ ] work [ ] my cell number: ______________________________

If unable to reach me:

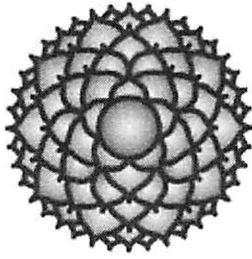
[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] Other: ______________________________

The best time to reach me is (day) ____________________ between (time) ____________

Signed: ______________________________ Date:____________________



Brevard
Health
Center

AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

NAME:____DOB:____________________________

ADDRESS:____

PHONE #:__________________________________DATE OF REQUEST:_______________________

Purpose of Release/Obtain Records: Continuity of Care (check one)

I authorize Brevard Health Center to RELEASE TO:_______________________________________

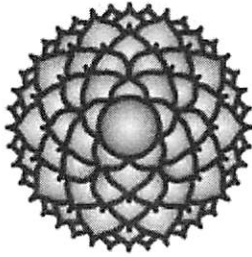
I authorize Brevard Health Center to OBTAIN FROM:_____________________________________

Any information, including diagnosis and medical records of any treatment or examination rendered to me, including diagnosis and medical records of any treatment or examination rendered to me to include any Federal and State protected information under Florida Statute (9) Psychiatric information, Florida Statute 397.053 and 396.112 Drug and/or Alcohol Abuse Information and Florida Statute 381.6002 (2) Human Immunodeficiency test Results (AIDS and related conditions).

I understand and direct that this authorization remains in effect for 6 (six) months or until I revoke it in writing. I hereby release your office or facility and its employees from any and all liability that may arise from the release of this information as I have directed.

____ ________________________

PATIENT SIGNATURE/EMPOWERED REPRESENTATIVE DATE



Brevard
Health
Center

OFFICE POLICIES AND INFORMATION

Initials:__________BLOODWORK/LABS: Please verify with your insurance company which is the preferred lab for blood draws to ensure accuracy of your benefits. You, the patient are given the lab orders at checkout. Please TAKE THIS LAB ORDER WITH YOU to the draw station. Although we do fax the order, technology does not always work accurately, so to reduce phone calls to the office and to reduce your frustration, PLEASE TAKE YOUR LAB ORDER WITH YOU.

Initials:__________CALL CONFIRMATIONS/MESSAGES FROM BHC: Please be mindful that call confirmations go out 2 days in advance of your upcoming appointment, emails as well. Please listen to the phone call(s)/message at it will reduce call to the office. When an employee of BHC calls you, the nurse will leave a message; it is prudent to listen to the message in its entirety. Please ensure that BHC has your updated contact information.

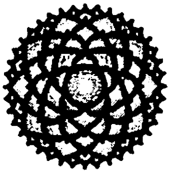
Initials:__________PRESCRIPTIONS: PLEASE CONTRACT THE PHARMACY and have them fax the request for refills(s) to our office @ (321) 215-6789. This ensures accuracy of patient information. Please give us a minimum of 24/48 hours to refill your medicine(s). Only call the office for refills in you have NO refills remaining. BHC does not prescribe narcotics. Waiting until you are completely out of medicine can be a health risk, please take charge of your medicine.

Initials:__________IMAGING/SCANS: When you have tests, imaging, etc. performed at an outside facility, please be aware that the results can take up to 5 business days and in some cases longer to be received. Follow-up appointments made to review results with the doctor are fruitful to your health if you have done your labs and imaging. BHC ONLY CALLS YOU WITH ABNORMAL RESULTS.

Inititals:__________BILLING/INSURANCE CARDS. Please notify the front desk of any insurance, address, and/or phone number updates. COPAYS/COINSURANCE/DEDUCTIBLES: PAYMENTS ARE DUE AT THE TIME OF SERVICE. BHC does it due diligence by verifying the patient's benefits; however, we have no control over how the insurance process the claim. Ultimately, it is the patient's responsibility to know your insurance benefits via employer/insurance carrier or employee handbook. Please call your insurance carrier for further details. BHC will send out monthly statements for any outstanding balances.

______________________________ ______________________________

PATIENT SIGNATURE DATE



298 Michigan Avenue
Suite 101
Melbourne, FL 32901
Phone: 321-215-6899

CANCELLATION/NO SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty five dollar ($25) fee; this will not be covered by your insurance company.

Print Name Patient ______________________

Signature Patient/Guardian__________________________

Date ____________________________

FORMS COMPLETION POLICY

Filling out forms requires careful consideration and considerable amount of our time.

It is our policy to charge for the completion of any forms. Processing fee is $50 per form.

- Family Medical Leave Act (FMLA)
- Schools
- Camps
- Long-term care
- Life insurance
- Department of Veteran's Affairs
- Driver's license elgibility
- Excludes Disability Forms - <u>We do not fill out disability forms.</u>