Brandon Area Primary Care

2024

Patient Acct#________

500 Vonderburg Dr 311W   282 Apollo Beach Blvd
Brandon, FL 33511-5978   Apollo Beach, FL 33572
www.brandondocs.com

Date:________________

Patient Information

Last Name: ______________________ First Name: ______________________ Middle initial: ________

DOB: ______________ Sex: ☐Male☐ Female Social Security# ________________ Marital Status: S M D W

Mailing Address: ____Apt# ______________

City:________________ State:______________ Zip Code:_____________ Phone:_______________

Email:______________________ Emergency Contact:____________________ Phone:______________

Employer:____ Phone:___________________

We are required to collect the following information for each patient. **Please circle one**. Thank you

Race: American Indian
Asian
Black or African American
Native Hawaiian
White
Decline to Answer

Ethnicity: Non-Hispanic or Latino
Hispanic or Latino
Other:________
Decline to Answer

Preferred Language: English
Spanish
French
Other:________

Primary Health Insurance:

Insurance Name:________________Policy#__________________Group#_____________Eff Date:______

Policy Holder:__________________ Policy Holder DOB____________ Policy Holder SS#_______________

Policy Holder Employer:___________________________________ Relationship to policy holder:_________

Secondary/Other Health Insurance:

Insurance Name:________________Policy#__________________Group#_____________Eff Date:______

Policy Holder:__________________ Policy Holder DOB____________ Policy Holder SS#_______________

Policy Holder Employer:___________________________________ Relationship to policy holder:_________

I hereby authorize Brandon Area Primary Care and its medical staff to perform medical procedure. I authorize the release of my medical information necessary for the processing of Insurance. I authorize the release of any medical information necessary to a physician to whom I am referred. A photocopy of the assignment of Financial Policy is to be considered as valid as an original. We cannot accept the responsibility for collection of your insurance claims nor for negotiating a settlement in a disputed claim. You are responsible for payment on your account. THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE ABOVE, AND IS THE PATIENT, GUARANTOR, OR THE PATIENT'S REPRESENTATIVE DULY AUTHORIZED TO EXECUTE THIS AGREEMENT AND ACCEPT ITS TERMS.

Date: ____________   Signature:_________________________________
Signature of patient or Representative

_________________________________   _______________________________
Representative's Relationship (if other than patient)   Witness

Name: | **DOB**:

ALLERGIES: Are you allergic to any drugs? YES/NO
If so, please list the drug name & reaction you had:

MEDICATIONS: YES/NO (if yes, please list including dosage)

MEDICAL ILLNESSES OR CONDITIONS: (That have been diagnosed) **IF NONE PLEASE WRITE THAT IN**

______________________ ______________________ ______________________

______________________ ______________________ ______________________

OPERATIONS: YES/NO

YEAR SURGERY

____ ______________________

____ ______________________

____ ______________________

HOSPITALIZATIONS: (admissions) YES/NO

YEAR SURGERY

____ ______________________

____ ______________________

____ ______________________

Family Medical History	Age	Health (list significant illnesses)	Age at Death	If deceased, cause	Comments
Father					
Mother					
Brother(s)					
Sister(s)					
Spouse					
Children					

HAS ANY BLOOD RELATIVE EVER HAD? (If yes-indicate relationship) Alzheimer's________ Bleeding Disease________
TB__________ Asthma_________ Diabetes______________ Heart attack before age 55__________ Alcoholism ______
Stroke___________ Seizures________________ High Blood Pressure________________ Heart Disease______________
Depression/Suicide________________ Mental Disorder______________ Cancer________________________

VACCINES: If yes- indicate when you received injection
Influenza_________ Covid 19___ ___ ___ ___ Prevnar 13/20______ Td/TDAP__________ Shingrix_____

SOCIAL HISTORY: **Alcohol Use:** Daily____ Occasionally _____ None_____
Tobacco Use: Never______ In the Past________ Presently _________ How much?_______ How long?__________

PHARMACY: Name__________________________ Address____
Phone _________________________ Fax _________________________

SIGNATURE: | **DATE**:

DOB: __________

PATIENT HEALTH QUESTIONNAIRE- (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Please circle your answer	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite- bring so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
____+____+_____+_____= total score____				

If you checked off **ANY** above problems, how **DIFFICULT** have these problems made it for you to do your work, take care of things at home, or get along with other people? (Please circle your answer)

Not difficult at all **Somewhat difficult** **Very difficult** **Extremely difficult**

PATIENT HEALTH QUESTIONNAIRE- (AUDIT-C) (please circle your answers)

1. **How often do you have 6 or more drinks on one occasion in the past year?**
   Never Monthly or less 2-4 times a month 2-3 times a wk 4+ times a wk
2. **How many standard drinks containing alcohol do you have on a typical day?**
   0 1-2 3-4 5-6 7-9 10+
3. **How often do you have a drink containing alcohol in the past year?**
   Never Less than Monthly Monthly Weekly Daily or Almost Daily

Name:	Signature:	Date:

ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I AUTHORIZE the release of any medical information, including without limitation, information related to psychiatric care, drug abuse, alcohol abuse, or **HIV/AIDS** confidential information that is needed for submission to my insurance carrier in order to process a claim or for utilization review or quality assurance activities.

I ASSIGN all medical and/or surgical benefits including major medical benefits to which I am entitled to **Brandon Area Primary Care**. A photocopy of this authorization shall be effective and valid as the original.

I AGREE to accept responsibility for any balance remaining after insurance pays or, if an HMO participant, any appropriate co-payment, deductible, or non-covered service. If I do not have insurance coverage, I agree to adhere to payment arrangements made at the time of my appointment, and to be responsible for any legal fees, cost, and expenses incurred by **myself** in the pursuit of the collection of fees due them for service provided.

I understand that this form or a copy thereof is valid for twelve (12) months.

_______________________________   _______________________________________

Date Signed   Patient/Subscriber Signature

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Billing Guidelines

Brandon Area Primary Care billing polices and a representative list of potential fees and charges are outlined below. This information is to ensure you are better informed at the time of service, and prior to the arrival of a billing statement. Please speak with the office manager if you have any questions regarding this information.

- **Co-Pays:** It is our policy to collect your insurance co-pay at check in. This simplifies the office process and ensures the financial obligation is met at the time of service.

- **Co-Insurance /Deductibles:** Every effort is made to fairly estimate the co-insurance or deductible owed based on the nature of the visit. It is our policy to collect these payments at the time of service.

- **Self-Pay Patients-** For established patients without insurance $84 will be collected upfront for estimated charge. For new patients $126 will be collected up front for estimated charge. If charges excesses $84/$126 dollars, the remaining balance will be collected at check out.

- **Billing:** As a courtesy, Brandon Area Primary Care bills your health insurance provider on your behalf.
    - **Insurance ID Card:** It is critical that the most current insurance ID card is brought to every appointment. We must have the correct information at the time of service.
    - **Auto Injury/Slip & fall/Third party-** We do not see patients or bill insurance for visits and medical care related to an auto injury/slip & fall/Third party accident. We can refer you to a facility without being seen by us to assist you with those issuses.
    - **Disability-** we do not fill out any disability forms for total disability. We will only do short term FMLA.
    - **Combined Visits-** If you are scheduled for a well exam (physical), and other health concerns are brought up that would typically require a sick visit, your insurance company may consider these two separate visits and bill your co-pay and other charges accordingly.
    - **Afterhours/Weekend surcharge-** Some health insurance providers bill a surcharge if you see your physician after normal business hours (8-5 pm), or on weekends (Saturday appointments).

- **Administrative Fees:**
  Brandon Area Primary Care charges fees for the following administrative tasks. (fees subject to change)

    - **Copies/Medical records:** $1 per page for first 25 pages and .25 cents for each additional page.
    - **Completion of forms:** FMLA, Sports/School physicals are free during a visit otherwise **$25.00**
    - **Physician letters:**.. **$25.00**
    - **Return Checks:** (for insufficient funds) **$20.00**
    - **"No-show" Fee:** Assessed if you do not show up for a scheduled appointment............. **$30.00**

- **Appointments:** As a courtesy, Brandon Area Primary Care provides a reminder call for your appointments, but this service is not always available. Our office must be notified at least 24 hours in advance, during business hours, if you intend to cancel an appointment.
- **Same-day appointments:** Our office must be notified of cancellation as least 4 hours in advance.

Our answering service does not accept appointment cancellations

______________________   ______________________   __________

Patient/Guardian Name (print)   *Signature*   *Date*

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

Title: Patient Self Determination act Questionnaire Rev B 2/16/2012

Name: ______________________________ Date: __________________

DON'T LOSE YOUR RIGHT TO DECIDE!

You cannot remove all uncertainty about your future healthcare needs but by having an advanced directive you can have the peace of mind that comes from making your wishes known in advance!

Declaration to Decline Life Prolonging Procedures (Living Will)

[ ] I have made a Living Will.

[ ] I have **NOT** made a Living Will.

Healthcare Surrogate

[ ] I have designated a Healthcare Surrogate.

[ ] I have **NOT** designated a Healthcare Surrogate.

Durable Power of Attorney

[ ] I have appointed a Durable Power of Attorney for Healthcare decisions.

[ ] I have **NOT** appointed a Durable Power of Attorney for Healthcare decisions.

If you have indicated that you have a living will, Healthcare Surrogate and/or a Durable Power of Attorney, please bring the fully executed document to your next visit so we can add it as part of your medical records.

____

(Print Name)

_______________________________________ ________________________

Signature of Patient or Representative Date

If you have any further questions, you can contact your family attorney, local hospital, or local medical association for additional information.

Brandon Area Primary Care

HIPPA Compliance Patient Consent Form

Name:	**DOB:**

May we phone, email, or send a text to you to confirm appointment? YES NO

May we leave a message on your voicemail at home or cell? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the person(s), if any, whom we may inform about your medical condition/diagnosis/treatment/payment/healthcare operations:

____

____

Please list the family members or significant others, if any, whom we may inform or call about your medical condition **ONLY IN AN EMERGENCY.**

Name:____________________ **Relationship**____________ **Phone Number**__________________

Name:____________________ **Relationship**____________ **Phone Number**__________________

Name:____________________ **Relationship**____________ **Phone Number**__________________

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- The practice reserves the right to change the privbavy policy as allowed by law
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revie this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Signature:	Date:
Witness:	Acct#

Privacy Practices and Patient Rights

How Your Information Is Used

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider

Health Care Options: As needed, we may use or disclose, your protected health information in order to support the business activities of your physician's practice

Admissible Unauthorized Disclosures

Law:
When required by local, state, or federal law.

Legal Proceedings:
We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Criminal Activity:
We may disclose your protected health information if we believe it is necessary to prevent or lessen a threat to the health or safety of a person or the public. Also, we may disclose this information to assist in the identification and apprehension of an individual.

Inmates:
We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Public Health/Communicable Disease:
We may disclose your protected health information if it may assist in the preventing or controlling disease, injury or disability.

FDA:
We may disclose your protected health information to a person or company required by the Food and Drug Administration

Child Abuse or Neglect:
We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect

Coroners, Organ Donation:
We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.

Close Identifiable Persons:
Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care.

Health Oversight:
We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Research:
We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Worker's Compensation:
We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Your Rights

You have the right to inspect and copy your protected health information:
Exceptions:: Psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding: and laboratory results that are subject to law that prohibits access to protected health information

You have the right to request a restriction of your protected health information:
You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You may have the right to have your physician amend your protected health information:
This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information:
This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices.

You have the right to obtain a paper copy of this notice from us.

Brandon Area Primary Care

Jason C. Stibich, M.D.	Kristine Rednour-PA-C
Natassa Quinn, M.D.	Joe Braden-PA-C
Mahin Baha, M.D.	Christina Elliott- APRN-C
Olan Halim, M.D.	Sarah Mastro- APRN-C
Mack Knowles, PA-C	Shannon Jamerson- APRN-C
Paula Proch, PA-C	Michael Pappas, APRN-C

To: All Patients of Brandon Area Primary Care

Dear Patient:

Welcome to Brandon Area Primary Care. The following information will help us better serve you.

In accordance with the Health Insurance Portability and Privacy act (HIPPA) and to ensure your ultimate privacy and confidentiality in this practice, only the patient will be allowed back in the exam rooms. However, if the patient is a minor child or a person with communication difficulties, one person may accompany the patient. Please understand that this is to ensure your ultimate privacy and confidentiality while you are a patient in this practice.

Listed below is information regarding your prescription, referrals and lab test results:

Prescriptions

1) Please bring your bottles of prescription medication with you to every visit.
2) If you need a refill, we will be glad to refill your prescription at the time of your visit.
3) If you need refills at any other time, please call our office and use ext: 3.
4) Please allow 48 hours notice to refill your prescription, not including weekends.
5) On occasion, you will be requested to see the doctor before refilling your medications over the phone.
6) Please be advised: Narcotic medications and many antibiotics cannot be filled over the phone.

Referrals for Managed Care companies (HMOs)

1) Please allow us a minimum of 3 working days to process your referral to a Managed Care company.
2) Some referrals may take longer, in which case we will make every effort to contact you.
3) Please leave appropriate information when calling our office with ext: 5.

Lab Test Results (X-Ray,Lab, etc)

1) Obtaining and processing your results take time. You can expect your results in writing within 1 to 2 weeks. If you do not receive a note from us within 2 weeks, please call our office.
2) Mammogram reports often take 2 or more weeks. Pap smear reports can take up to 6 weeks.

We appreciate your cooperation in the above matters.

Sincerely,

Brandon Area Primary Care