# BRIGHT CARE MEDICAL GROUP

The safety of our patients and staff members remain our overriding priority here at Bright Care Medical Group. As the coronavirus disease 2019 (COVID19) outbreak continues to evolve, Bright Care Medical Group is monitoring the situation closely and will adjust our policy and procedures according to the guidance from the Centers of Disease Control and the World Health Organization.

To prevent the spread of COVID19 and reduce the potential risk of exposure to our patients and staff members, we are conducting a simple screening questionnaire. Your participation is important to help us take precautionary measures to protect you and all of our patients and staff members. Thank you for your patients and time.

## Self – Declaration by Visitor

| | |
|---|---|
| 1 | Have you traveled to any of the following countries – **China, Iran, Italy, Japan, South Korea, or Europe except the UK?** |
| 2 | Have you had close contact with or cared for someone diagnosed with COVID-19 with in the last 14 days? |
| 3 | Have you experienced any cold or flu like symptoms in the last 14 days - including: fever, cough, sore throat, respiratory illness, or difficult breathing? |

Patient Signature _____ Date _____

Print Name _____

# BRIGHT CARE MEDICAL GROUP

## PATIENT INFORMATION

Patient's Name _____ Phone #_____

Address _____
Street City State Zip Code

Social Security # _____ Date of Birth ____/____/_____ Age _____ Sex: __M __F

Employer _____ Occupation _____

Emergency Contact _____ Phone #_____

Email _____

Marital Status: __Single __Married __Widowed Preferred Language: Englis __Spanish __
Race: __American Indian/Alaskan __Asian __African American __Caucasian __Hawaiian __Other:_____
Pharmacy _____
Name Address Phone #

## PRIMARY INSURED

___Self (if self, you do not need to complete the rest of this section) ___ Spouse ____ Parent Other: _____

Name _____ Phone #_____

Address _____
Street City State Zip Code

Social Security #_____ Date of Birth: ____/____/_____ Age:_____ Sex: __M __F

## INSURANCE

**Primary Insurance Company Name:**_____ Phone #: _____
Address: _____ City:_____ State: _____ Zip: _____
ID#:_____ Group #:_____

**Secondary Insurance Company Name:** _____ Phone #: _____
Address: _____ City: _____ State:_____ Zip:_____
ID#: _____ Group #:_____
If not self:
Insured Name:_____ Insured Date of Birth: ___/____/_____ Insured Social Security #:_____

_____
**Patient/ Guardian Signature** **Date**

(03/18)

Bright Care Medical Group LLC

Name: _____ Sex: M F DOB: _____

| What brings you to see me today? |
|---|
| |

Do YOU have any drug allergies: ☐ Penicillin ☐ Sulfa ☐ Tetracycline ☐ Other

## Family Health History

This pertains to YOUR BLOOD (genetic) relatives ONLY

| Relative Type | Living (L) or Deceased (D) | Current age/age @ death | Cause of death | Health condition you wish me to know about |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Brother (s) | | | | |
| Sister (s) | | | | |
| Mother's Father | | | | |
| Mother's Mother | | | | |
| Father's Father | | | | |
| Father's Mother | | | | |
| Child(ren) | | | | |
| ☐ I was adopted | | | | |

## Your Chronic Medical Condition(s)

| Chronic Condition | Year Diagnosed | Chronic Condition | Year Diagnosed |
|---|---|---|---|
| Diabetes | | Hypertension | |
| COPD, Bronchitis, Asthma | | High cholesterol | |
| CAD/ Heart attack | | Hypothyroidism | |
| CHF (heart failure) | | Depression (anytime throughout life) | |
| Pacemaker/ Defibrillator | | Acid Reflux (GERD) | |
| Atrial Fib/ Heart Arrhythmia | | Cirrhosis/ Hepatitis A B C | |
| Peripheral Vascular Disease | | Gout/ Osteoarthritis | |
| DVT (blood clot) | | Erectile Dysfunction | |
| Stable Chest Pain (angina) | | Sleep Apnea | |
| Seizures/ Epilepsy | | Cataracts/ Glaucoma | |
| Stroke/ TIA | | Parkinson's | |
| Dementia/ Alzheimer Disease | | Mechanical Valve | |
| Rheumatoid Arthritis | | Cancer: | |
| HIV/ AIDS | | Chemo Tx/ Radiation | |
| Neuropathy | | Dependency (drug/ alcohol) | |
| Migraines | | Amputation: where? | |

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Name: _____ Sex: M F DOB: _____

## Review of Systems

Please circle all that you have experienced within the **past 6 months**

| | | | | |
|---|---|---|---|---|
| Fever / Chills | Dizziness/ spinning | Fainting | Forgetfulness | Headache |
| Sweating | Weakness | Weight loss/ gain | Numbness | Nervousness |
| Loud snoring | ↑ Daytime sleepiness | Trouble sleeping | Imbalance | Hives/ rash |
| Diarrhea | Indigestion/ heartburn | Constipation | Nausea | Vomiting |
| Rectal bleeding | Dark colored stools | Abdominal pain | ↑ Urination | Blood in urine |
| Painful urination | Incontinence (leakage) | Trouble swallowing | Bruising | Itching |
| Change in skin | Non- healing sores | Vision changes | Earaches | Loss of hearing |
| Discharge of ear | Hoarseness | Ringing in ears | Nosebleeds | Sore throat |
| Sinus issues | Teeth / gum concerns | Congestion | Cough | Shortness of breath |
| Palpitations | Chest pain/ discomfort | Leg swelling | Varicose veins | Pain in legs with walking |
| ↑ Thirst | ↑ Hunger | Cold/ burning feet | Joint pain | Breast / nipple discharge |
| Vaginal discharge | Breast lump | Penial discharge | Testicle lump | Painful intercourse |

**Smoking History:** ☐I was NEVER a smoker ☐CURRENT smoker ☐FORMER smoker

I currently smoke: ____(number of packs daily) for ____ (number of years)

I did smoke: ___ (number of packs daily) for ___(number of years) & quit in _____(enter year)

**Alcohol History:** ☐I have never drank ☐I am a current drinker ☐I drank but now do not

I currently drink____ (number of alcoholic beverages) Daily Weekly Monthly (please circle)

Previously I drank ___ (number of alcoholic beverages) Daily Weekly Monthly (please circle)

I quit in _____ (enter year). I have attended AA in past ____ NO ___ YES

**Illicit Drug History:** I have used illicit drugs: ☐ NEVER ☐CURRENTLY ☐ IN PAST

Type of drug: Marijuana Cocaine Methamphetamine Heroin Other:_____

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Name: _____ Sex: M F DOB: _____

## Prevention & Maintenance of your Health

| Type | MM/DD/YYYY | Type | MM/DD/YYYY | Type | MM/DD/YYYY |
|---|---|---|---|---|---|
| Flu Vaccine | | Mammogram | | Heart Cath | |
| Pneumonia Vaccine | | Pap Smear<br>Last Menses:<br>Hysterectomy: Y N | | ECHO (ultrasound of heart) | |
| Shingles | | Bone Density | | Stress test | |
| Hep B series | | Colonoscopy<br>Polyps: Y N | | Chest Xray | |
| Eye Exam | | Endoscopy (EGD)<br>Barrett's Y N | | Prostate Exam/ PSA | |

## Blood Transfusion (s)

Please list dates & reason for transfusion (s)

| Date (s) | Reason |
|---|---|
| | |
| | |

## Hospitalizations in the past 1 year

| Reason for hospitalization | Date |
|---|---|
| | |
| | |
| | |
| | |

## Surgical History (All major surgeries)

| Procedure Type | Date |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## Fractures

| Type/ Bone | Date |
|---|---|
| | |
| | |

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Name: _____ Sex: M F DOB: _____

**Please list all medications in the following tables. Please pay attention to table headings.**

## OVER THE COUNTER MEDICATION (S)

| Name of medication | Dose | How many times a day |
|---|---|---|
| | | 1 2 3 4 ☐ as needed |
| | | 1 2 3 4 ☐ as needed |
| | | 1 2 3 4 ☐ as needed |
| | | 1 2 3 4 ☐ as needed |
| | | 1 2 3 4 ☐ as needed |

## PHYSICIAN PRESCRIBED MEDICATION(S)

| Name of medication | Dose | How many times a day |
|---|---|---|
| | | 1 2 3 4 ☐ as needed |
| | | 1 2 3 4 ☐ as needed |
| | | 1 2 3 4 ☐ as needed |
| | | 1 2 3 4 ☐ as needed |
| | | 1 2 3 4 ☐ as needed |
| | | 1 2 3 4 ☐ as needed |
| | | 1 2 3 4 ☐ as needed |
| | | 1 2 3 4 ☐ as needed |
| | | 1 2 3 4 ☐ as needed |
| | | 1 2 3 4 ☐ as needed |
| | | 1 2 3 4 ☐ as needed |

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Name: _____ Sex: M F DOB: _____

# Other Providers Participating In My Healthcare

| Type | Name of Doctor | Phone number |
|---|---|---|
| Cardiologist | | |
| Dermatologist | | |
| ENT ear/nose/throat) | | |
| Gastroenterologist | | |
| GYN | | |
| Nephrologist | | |
| Oncologist | | |
| Ophthalmologist | | |
| Orthopedist | | |
| Psych (counselor) | | |
| Pulmonologist | | |
| Rheumatologist | | |
| Urologist | | |
| | | |
| | | |

## My last Primary Care Doctor was:

**Name:** _____

**Phone Number:** _____

## Advance Directive/ Living Will/ Power of Attorney/ 5 Wishes/ DNR

I understand that I have the right to accept and refuse medical treatment and to exercise my right and implement an Advance Directive. An Advance Directive refers to any legal document that informs family members and medical personnel how you wish to be treated if you are hospitalized and cannot communicate your wishes. Please check the following statements that apply: We would like a copy for our records.

___ I have executed an Advanced Directive ___ I have NOT executed an Advance Directive

Check the one(s) you have and can provide copies of to our office:

oLiving Will oDurable Medical Power of Attorney o5 Wishes oDo Not Resuscitate (DNR)

_____ _____ _____/_____/ 20___

Signature Printed Name Date

Patient Consent for Use & Disclosure of Protected Health Information

I hereby give my consent for Bright Care Medical Group to use and disclose protected health information about me to carry out treatment, payment and health care operations (TPO). The Notice ofPrivacy Practices provided by Bright Care Medical Group describes such uses and disclosures more completely.

I have the right to review the Notice ofPrivacy Practices prior to signing this consent. Bright Care Medical Group reserves the right to revise its Notice ofPrivacy Practices at any time. A revised Notice ofPrivacy Practices may be obtained by forwarding a written request to Bright Care Medical Group.

With this consent, Bright Care Medical Group may call my place of residence or other alternative location and leave a message on voice-mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Bright Care Medical Group may mail to my home or other alternative locations, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Bright Care Medical Group restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but ifit does, it is bound by the agreement.

By signing this form, I am consenting to allow Bright Care Medical Group to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. IfI do not sign this consent, or if I later decide to revoke it, Bright Care Medical Group may decline to provide treatment to me.

TPO Definition: Treatment, Payment, Operation

_____ _____ _____/_____/20____

Signature Printed Name Date

## HIPAA Privacy Authorization Form
## Authorization for Use or Disclosure of Protected Health Information

I authorize Bright Care Medical Group to use and disclose my protected health information as described below:

1. Extent ofInformation to be released
   a. I authorize the release of my COMPLETE health record (including records relating to my mental health as well as treatment ofalcohol and/ or drug abuse initials: _____
   b. I authorize the release of my COMPLETE health record with the **EXCEPTION** of the following information: (please initial next to the records to exclude)
      1. _____ Mental Health records
      2. _____ Alcohol/ dmg abuse treatment
      3. _____ Other: (please specify): _____
2. This medical information may be used by the entity I authorize to receive this information for medical treatment, consultation, billing/ claims, payments, or other purposes as I may direct.
3. This authorization shall be in force and effective until
   a. _____ (list date)
   b. Twelve months from date this form is signed **Initials:** _____
4. I understand that I have the right to revoke this authorization at any time. I further understand that in order to revoke I must submit in writing. I understand that the revocation is not effective to the extent that any person/ entity has already acted in reliance on my authorization of if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim.
5. I understand that my treatment, payment, enrollment, and/ or eligibility for benefits will not be conditioned on whether I sign this authorization.
6. I understand the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state laws.
7. I authorize the release of information to include diagnosis, records, exams rendered to me, and claims data to the following individuals:
   a. Spouse: Name: _____
   b. Child(ren): Name(s) _____
      _____
   c. Other (please indicate relationship) _____
8. Messages regarding my healthcare may:
   a. _____ (initial) be left on any one of my messaging systems using the numbers I have provided
   b. _____ (initial) NOT be left on any messaging system. I would like a message to return the provider's call instead.
9. Fax Number of Bright Care Medical Group LLC 352-708-6153 Telephone Number 352-708-3021

_____ _____ _____/ _____/ 20____

Signature Printed Name Date

## Prescription Pick- up Authorization

Last Name: _____ First Name: _____

Date of Birth: _____/_____/_____

I hereby authorize the individual(s) listed below to pick up my prescribed prescription(s) from any of the Bright Care Medical Group locations. Bright Care Medical Group staff reserves the right to request proof of identity to pick up any prescriptions. My representative must be able to provide a valid photo identification. I further understand that any individual who is not listed will NOT be able to pick up my prescriptions. I am able to change this authorization at any time but understand that the changes MUST be submitted in writing to Bright Care Medical Group.

| Name of authorized person (please print legibly) | Relationship to patient named above |
|---|---|
| | |
| | |
| | |
| | |

_____ _____ _____/_____/20____

Signature Printed Name Date

## Consent to Release Confidential Information

Last Name: _____ First Name: _____

Last 4 of SS#: _____ Date of Birth: ____/____/ _____

I hereby authorize that a copy of my medical records be released to the following:

Records to be released to: Records to be released from:

_____

Phone: _____

Fax: _____

Please initial next to option of your choice:

_____ This release is to cover **ALL** records contained in my medical chart to include psych, drug, & any alcohol treatments.

_____ This release is to cover ALL records contained in my medical chart EXCEPT:

_____ Any psychiatric records/ treatment

_____ Any drug related records/ treatment

_____ Any alcohol related records/ treatment

I understand that the purpose of the record release is for continuity of my medical care. The information contained in my medical records (s) may include diagnosis, evaluation and/ or treatment of any mental or emotional condition (s). This may also include alcohol and/ or drug related addictions. Information regarding HIV infection with any probable causative agent of AIDS are also considered a part of my medical record. The expiration of this release is one year from the date of signature. I may revoke this authorization at any time by notifying and providing ---------- in writing. The written revocation will be effective on the date of notification except to any actions already taken. Any information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the Federal privacy regulations. By authorizing the use or disclosure if information, there will be no conditions placed on my health care of payment of my health care. I have the right to receive a copy of this form after I have signed it. In compliance with Florida State Law, I may be required to pay a fee for any retrieval and photocopying of records and/ or supervising inspections of medical records.

_____ _____ _____ 20__

Signature Printed Name Date

# Patient Responsibility Form

1. The patient is responsible for providing Bright Care Medical Group with the most correct, active and up to date information about their insurance prior to each visit.
2. Bright Care Medical Group will bill to the insurance most recently provided by the patient. If information given by the patient is inaccurate and the insurance denies the claim, the patient will be responsible for the balance of the visit. Please be aware that with some insurance companies there are timely filing deadlines by providing correct information at tine time of service is critical. Timely filing means the patient's insurance plan may not pay the claim after a certain amount of time after the service.
3. Patients are responsible for the payment of co-pays at the time of service.
4. Patients are responsible for paying any applicable co-insurance, deductibles and all other procedures or treatment not covered by their insurance plan.
5. Bright Care Medical Group is not responsible for knowing what each individual insurance plan does or does not cover. If the patient has questions about their plan and what services are covered, they should contact their insurance
6. In the event a patient's health plan determines a service to be "not payable", the patient will be responsible for the complete charge and agree to pay the costs of all services provided.
7. Patients have the right to check with their insurance about coverage before receiving any service provided at Bright Care Medical Group.
8. The patient's health insurance policy is a contract between the patient and their Health Insurance Company or employer. It is the patient's responsibility to know if their insurance has specific rules or regulations, such as the need for referrals, pre-certifications, per-authorizations and limits on outpatient charges regardless of whether our physicians participate.
9. The patient is responsible for knowing if our doctor is in-network with their insurance plan and if the services are covered. Any balances applied to an out of network rate will be the responsibility of the patient to pay.
10. If the patient is uninsured, the patient agrees to pay for the medical services rendered to them at the time of service.
11. Medicare may not cover some of the services that the patient's doctor recommends. The patient will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help the patient decide whether they want to receive services, knowing they may be responsible for payment. Patients should read the ABN carefully.
12. The patient agrees that in return for the services provided to them by Aegis Medical Group, they will pay their account at the time service is rendered or upon insurance claim processing- If a payment plan is necessary, the patient understands that the agreement is for past due balances only, and that all future co-payments, co-insurances and/or deductibles, are due at the time of service. If
13. co-payments, co-insurances and/or deductibles are assigned by the patient's insurance company or health plan, they agree to pay them to Bright Care Medical Group.

**Worker's Compensation and Automobile Claims**
Bright Care Medical does not accept and/or file workers comp or auto claims.

I have read the above and understand the contents of this form. I have been given the opportunity to ask any questions and I am satisfied with my current knowledge regarding Bright Care Medical Group policies regarding patient responsibilities.

| _____ | _____ | _____/_____/ 20____ |
|---|---|---|
| Signature | Printed Name | Date |