BEACON HEALTH

PATIENT REGISTRATION				
First Name:	Last Name:	MI:	D.O.B.	○ Male ○ Female
Select One: ○ Full-Time Resident (Year Round) ○ Winter Resident (Apr-Oct) ○ Summer Resident (May-Sept)				
Street Address:			SSN#: ○ Married ○ Divorced ○ Single ○ Widowed	
Home Phone:	Cell Phone:	Work Phone:	Preferred Language:	
Referring Physician:			Ethnicity: ○ Hispanic or Latino ○ Non-Hispanic or Non- Latino	
❑ Black or African American_____ ❑ Asian_____ ❑ American Indian or Alaska Native_____ ❑ Other Race_____ ❑ Native Hawaiian or Other Pacific Islander_____ ❑ White_____				

EMERGENCY CONTACTS		
Name:	Relationship:	Home/Cell Phone:
Name:	Relationship:	Home/Cell Phone:

GUARANTOR (if other than patient):	
Name:	Relationship:
Address:	City,State,Zip:
Home/Cell Phone:	Work Phone:

PRIMARY INSURANCE:	**SECONDARY INSURANCE:**
○ Same as Patient ○ Same as Guarantor ○ Other_____	○ Same as Patient ○ Same as Guarantor ○ Other_____

First Name:	Last Name:	D.O.B.:

To improve interactions and communications with our patients, we have implemented automated systems for phone messages and for email communications concerning appointment reminders, past due balance alerts, and disease management initiatives, etc.

May we place automated phone calls or email messages with you?

- Yes
- No

If "Yes", please indicate your preferences below:

Health Notifications:	**Appointment Reminders:**	**Announcements:**	**Billing Information:**
○ Email ○ Phone ○ Text	○ Email ○ Phone ○ Text	○ Email ○ Phone ○ Text	○ Email ○ Phone ○ Text
Email Address:	How did you hear about us?	○ TV ○ Social Media ○ Radio	○ Newspaper Ad ○ Friend ○ Other_____

ASSIGNMENT AND RELEASE:

- I hereby assign my insurance benefits to be paid directly to Beacon Health Internal Medicine.
- I agree to be solely responsible for all collection fees, attorney fees, and court costs necessary to collect payment on any portion of the delinquent balance, and I hereby authorize Beacon Health Internal Medicine to conduct any and all financial investigative reports that they deem necessary to determine if service is to be provided and if any payment arrangements can be made.
- I understand that if I fail to cancel or reschedule an appointment, I may be charged a “NO SHOW” fee.
- I authorize the physician to release any medical information required to process the claim.
- I authorize electronic communications from Beacon Health Internal Medicine for healthcare maintenance purposes (I.E., emails, phone calls, and Beacon Health Communicator Portal messages.

Signature: _____ Date: _____

OFFICE POLICIES AND FINANCIAL INFORMATION

APPOINTMENTS: Patients are seen by appointment only. In order to schedule enough time for your visit, you will be asked to disclose which specific medical concern(s) you would like to address. Please do not anticipate on the day of your appointment to go over a 'list' of multiple medical complaints unrelated to the initial reason for your visit; these can be scheduled for a subsequent day. This ensures enough time to focus on your main concerns, while being respectful of other patients scheduled appointment times. If you anticipate being late to an appointment, we ask you contact us as soon as possible. PATIENTS WHO ARRIVE AFTER THEIR APPOINTMENT TIME MAY BE RESCHEDULED.

CANCELLATIONS: If you need to cancel or reschedule an appointment, please call us 24-hours in advance. Failing to show up for a scheduled appointment will result in a $50 No-Show Fee.

PROOF OF INSURANCE: Prior to being seen by a provider, you must present a valid legal identification card and proof of current medical insurance. Beacon Health contracts with multiple insurance companies and it is YOUR responsibility to know insurance benefit coverage, including any out-of-pocket requirements. If you are self-pay or Beacon Health does not participate with your insurance plan, payment in full is required at time of service. If it becomes necessary to place your account with a third-party collection agency due to non-payment, you may be discharged from the practice.

DISMISSAL: There are several circumstances warranting discharge from our practice which include but not limited to: frequent no-shows, failure to pay your bill, threatening or abusive behavior towards staff and non-compliance with office policies. Should this occur, Beacon Health will provide medical treatment on an emergency only basis for the next 30 days.

BOUNCED CHECKS: A $50 charge will be applied to each check returned by your financial institution.

TEST RESULTS: We will contact you immediately with any emergent results of diagnostic tests or labs ordered by a Beacon Health provider. If you are requesting to review a non-emergent test with a provider you will need to schedule a follow-up appointment. All results are published to the online patient portal following provider review and/or discussion with the patient. If you are unable or elect not use the portal, you have an option to be contacted via telephone by our support staff. This may be subject to a professional fee. Please allow 5 business days for providers to receive and review test results before contacting our office.

PROVIDERS: Beacon Health is a GROUP practice that may at any given time consistent of various providers; Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.), Physician Assistants (PA-C) and Nurse Practitioners (N.P.). All are licensed through the Florida Department of Health to provide quality medical care. Although we try to honor patient requests for appointments with a specific provider, there may be circumstances when this cannot be accommodated. All providers at Beacon Health are part of a collaborative team and will have access to your medical record during regular office hours.

AFTER-HOURS CALLS: For any urgent need that cannot wait until business hours the following day, you may call the office and be directed to the on-call provider. IF YOU HAVE AN EMERGENCY, YOU MUST CALL 911 OR GO TO THE NEAREST EMERGENCY DEPARTMENT. The after-hours line is NOT to be used to request treatment for any new medical problems or prescriptions. Should this occur, you may be billed for a telehealth visit and therefore responsible for any co-pays or fees not covered by your insurance company. KEEP IN MIND PROVIDERS MAY NOT HAVE ACCESS TO YOUR MEDICAL CHART AFTER BUSINESS HOURS.

PRESCRIPTIONS: Please allow 48 hours for all prescription refill requests to be sent in. If you submitted a request and have not received a "ready" notification from the pharmacy, please contact the pharmacy PRIOR to calling our office. If you have a medical conditioning warranting long-term use of a controlled substance you will be required to sign a Controlled Substance Contract Form prior to a prescription being issued. Any controlled substance issued through Beacon Health is at each individual provider's discretion and in accordance with the Florida Department of Health statutes.

MEDICARE ANNUAL WELLNESS VISITS: There is a difference between an "Annual Wellness Visit and an "Annual Physical Examination". An Annual Wellness Visit covered by Medicare includes a review of your social and medical history, education and counseling about preventative services, depression screening, an offer to discuss advanced directives and a height, weight and blood pressure measurement. It does not include a physical examination. As a convenience to the patient, if one chooses to have a physical examination or discuss any other topics with a provider during their Medical Annual Wellness Visit, you may be billed for an office visit and be responsible for any associated co-pays. This policy is created by Medicare and not Beacon Health.

At Beacon Health we strive to address all of your healthcare needs while providing optimal care. Should you have additional questions regarding the office or financial policies, please contact our office.

My signature below confirms that I have received and agree to abide by the above Office and Financial Policies of Beacon Health.

_____

Patient/Legal Representative Signature **Printed Name and Date**

PATIENT REPRESENTATIVE AUTHORIZATION

Please write your NAME and DATE of BIRTH. Complete and sign either SECTION (1) or SECTION (2)

Patient Name: Date of Birth:

(1.) I DO AUTHORIZE PATIENT REPRESENTATIVE(S) AS FOLLOWS:

I, _____, hereby authorize Beacon Health Internal Medicine Providers to discuss my care/condition with the following person(s):

Name: _____

Address: _____

City/State/Zip: _____

Relationship: _____

Phone: _____

Name: _____

Address: _____

City/State/Zip: _____

Relationship: _____

Phone: _____

Medical information that may be discussed/disclosed may include (check all that apply):

- ❑ Alcohol and/or Drug Abuse
- ❑ Acquired Immunodeficiency Syndrome (AIDS)
- ❑ Sexually Transmitted Disease (STD)
- ❑ Human Immunodeficiency Virus (HIV)
- ❑ Mental Health

*This authorization to discuss/disclose my private health information to the designated person(s) named above **shall expire** (please make a selection):*

- ❑ *12 months from the date of my signature below – OR --*
- ❑ *When I revoke this authorization by sending written notification to Beacon Health Internal Medicine.*

I understand that I have the right to inspect the medical records requested and that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by State or Federal Law.

_____ _____ _____

Print Patient Name | Signature Patient or parent/legal guardian | Date

(2.) I DO NOT WANT TO AUTHORIZE PATIENT REPRESENTATIVE AT THIS TIME

I, _____, do not want to name a patient representative at this time.

_____ _____ _____

Print Patient Name | Patient/Legal Representative Signature | Date

MEDICAL HISTORY

Patient Name: _____ ID# _____ D.O.B. _____ TODAY'S DATE: _____

PATIENT CARE TEAM	Name/Specialty	Address	Phone
Primary Care Provider			
Specialists			

PHARMACY	Address/Location	Phone # (if known)
Preferred Pharmacy (local)		
Preferred Pharmacy (mail order)		

MEDICATIONS: include vitamins, herbal medicines, frequently used over-the-counter medications (ibuprofen, tylenol, aspirin, tums, etc.)

Name	Dose-(mg)	Directions
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8		

ALLERGIES (attach separate sheet if needed)

Are you allergic to contrast dye? **YES __ NO __**

Allergic to:	Reactions:
1.	
2.	
3.	

IMMUNIZATIONS

Name:	Date:	Name:	Date:	Name:	Date:
Flu		Tetanus		Pneumonia 13	
Zoster(shingles)		Hepatitis		Pneumonia 15	
		Other		Pneumonia 20	
				Pneumonia 23	
	1st Dose:	2nd Dose:	Booster 1:	Booster 2:	Booster 3:
Covid-19					

Patient Name: _____ ID# _____ D.O.B. _____ TODAY'S DATE: _____

PAST MEDICAL HISTORY Check all that apply.	
○ Alcohol Overuse	○ Hepatitis
○ Allergies (other than meds)	○ High Blood Pressure
○ Amputation (location)	○ High Cholesterol
○ Anemia	○ HIV/AIDS
○ Anxiety/Stress	○ Hormone Replacement
○ Arthritis	○ Hospitalizations other than Operations
○ Asthma	○ Jaundice
○ Back Pain	○ Kidney Disease
○ Barrett's Esophagus	○ Kidney Stones
○ Bleeding Disorder	○ Measles/Mumps
○ Blood Thinner Treatment	○ Memory Loss/Alzheimer's
○ Cancer (location)	○ Nerve Damage/Neuropathy
○ Cardiac Arrythmias/Irregular Heart Rate	○ Nervous Breakdown
○ Cardiac Pacemaker/DeFib	○ Osteopenia/Osteoporosis
○ Chicken Pox	○ Ostomies (location)
○ Cirrhosis	○ Other
○ Colon Polyps	○ Paralysis
○ Colon Problems	○ Parkinson's
○ Congestive Heart Failure	○ Prostate Problems
○ Crohn's Disease	○ Rash/Skin Condition
○ Depression	○ Rheumatic Fever
○ Diabetes	○ Seizures
○ Emphysema/COPD	○ Serious Injuries
○ Erectile/Sexual Dysfunction	○ Sexually Transmitted Disease
○ Falls	○ Sleep Disorder/Insomnia
○ Gallbladder Disease	○ Stroke/TIA
○ Gastritis	○ Thyroid Disease
○ GERD/Ulcer	○ Urinary Problems
○ Gout	○ Vascular Disease
○ Headaches/Migraines	○ Visual Problems
○ Heart Disease/Heart Attack	○

Patient Name: _____ ID# _____ D.O.B: _____ TODAY'S DATE: _____

SURGICAL HISTORY List all surgeries/procedures and the year.		
	Name of Surgery	**Year**
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
Do you have a Pace Maker? YES __ NO __		

HEALTH MAINTENANCE List date of last exam.	
	Year
Stress Test	
Echocardiogram	
EKG	
Chest X-Ray	
Mammogram	
Pap Smear	
Bone Density	
Colonoscopy	

FAMILY HISTORY		
○ I do not know my family history	○ Mother is living ○ Mother is Deceased Age of Death: Cause of Death:	○ Father is living ○ Father is Deceased Age of Death: Cause of Death:

If a blood relative (parent,sibling,child) has any of the following, please check and indicate which family member.

▫ Alcoholism	▫ Diabetes	▫ Mental Illness	▫
▫ Breast Cancer	▫ Heart Attack	▫ Osteoporosis	▫
▫ Colon/Rectal Cancer	▫ Heart Disease	▫ Skin Cancer	▫
▫ Colon Polyps	▫ High Blood Pressure	▫ Stroke	▫
▫ Depression	▫ High Cholesterol	▫ Other	▫

SOCIAL HISTORY			
Occupation:			Retired: YES __ NO __
Marital Status: Married ___ Widow/er ___ Single ___ Divorced ___			# Of Children: / # Of Pregnancies:
Alcohol: Yes __ No __ Type: _____ Frequency: Number of drinks ____ Day __ Week __ Month __	Smoke: Yes __ No __ Frequency: Number Pack/Day _____ Number of Years _____ Quit Date: _____	Exercise: Yes __ No __ Type: _____ Frequency: Number of Times _____ Day __ Week __ Month __	Illicit Drug Use: Yes __ No __ ▫ Marijuana ▫ IV Drug Use

I hereby authorize *Beacon Health Internal Medicine to obtain for my medical records any medication history that is automatically downloaded from the Pharmacy Benefits Manager through SureScripts.*
Patient Signature:

I hereby authorize *Beacon Health Internal Medicine to disclose my medical records and health care information to other medical providers and facilities upon their request in connection with my medical care and treatment.*
Patient Signature:

I hereby authorize *Beacon Health Internal Medicine to exchange my immunization history with the Florida Immunization Registry.*
Patient Signature:

PATIENT BILL OF RIGHTS

Section 821.026 Florida Law requires that your healthcare provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A PATIENT HAS THE RIGHT TO:

- Know what rules and regulations apply to his or her conduct.
- Be treated with courtesy and respect, with appreciation of his or her individual dignity, and, with protection of his or her need for privacy.
- Receive a prompt and reasonable response to questions and requests.
- Impartial medical treatment or accommodations regardless of race, national origin, religion, handicap, sexual orientation, or source of payment.
- Know who is providing the medical services, and who is responsible for his or her care.
- Be given, by the health care provider, information such as diagnosis, planned course of treatment, alternatives, risk and prognosis.
- Know if medical treatment is for purposes of experimental research, and, to give his or her consent or refusal to participate in such research.
- Bring any person of his or her choosing to the patient-accessible areas of the health care facility to accompany the patient while patient is receiving treatment or is consulting with his or her health care provider unless doing so would risk the safety or health of the patient, other patients, staff of the facility, or cannot be reasonably accommodated.
- Refuse any treatment except as otherwise provided by law.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Receive, upon request and prior to treatment, a reasonable estimate of charges for medical care.
- Know, upon request and in advance of treatment whether the health care provider or health care facility accepts the Medicare assignment rate if he or she is eligible for Medicare.
- Receive, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- Know what patient support services are available, including if an interpreter is available if the patient has hearing or vision loss, or does not speak English.
- Receive a copy of a reasonably clear, understandable itemized bill and, upon request, to have the charges explained.
- Express grievances regarding any violation of his or her rights, as stated in Florida Law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate licensing agency.

A PATIENT IS RESPONSIBLE FOR:

- Giving the health care provider accurate information about present complaints, past illnesses, hospitalizations, medications and any other matter relating to his or her health.
- Reporting to the health care provider whether her or she understands a planned course of action and what is expected of him or her.
- Following the treatment plan recommended by the health care provider.
- Reporting unexpected changes in his or her condition to the health care provider.
- His or her actions if treatment is refused or if he or she does not follow the health care provider's instructions.
- Following health care provider's or health care facility's conduct rules and regulations.
- Keeping appointments and, when unable to do so, notify the health care provider or facility.
- Assuring that financial obligations of his or her health care are fulfilled as promptly as possible.