Brevard Health Alliance (BHA)
PATIENT REGISTRATION FORM
If you need help filling out this form, please let us know.
Please have Photo ID, Social Security Card, and Insurance Card ready for Staff

Today's Date:	

BHA After Hours (Provider on Call): (321) 951-8463 (to evaluate urgent situations, for emergencies call 911)	Language/ASL Translator needed? Yes Explain:_____ No

PATIENT INFORMATION

Last Name	MI	First Name	Date of Birth	Age

Street Address	City	State	Zip

Primary Contact Phone #:	Alternate Contact #: ☐Work ☐Home	SSN
Email Address	Would you like access to the patient portal? ☐ Yes ☐ No	

Preferred Pharmacy:			Other pharmacy name and location:
	☐ 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	

Parent/Guardian Name (minors only):	Relationship:	Parent/Guardian DOB	Address: ☐ Same as above	Phone Number
Parent/Guardian Name (minors only):	Relationship:	Parent/Guardian DOB	Address: ☐ Same as above	Phone Number

MEDICAL INSURANCE INFORMATION

Person Responsible for Bill	Birth Date	Address (if different)	Phone Number

Relationship to Subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Step Child ☐ Other _____

Primary Insurance:
Insurance Company_____ ☐ No Insurance (Wish to apply for Sliding Fee Scale)
☐ No Insurance (Declining the Sliding Fee Scale)

Subscriber Name	Subscriber ID/Policy #	Group #	Subscriber DOB	Subscriber SSN	Co-Pay $

Secondary Insurance:
Insurance Company_____ ☐ No Insurance (Wish to apply for Sliding Fee Scale)

Subscriber Name	Subscriber ID	Group #	Subscriber DOB	Subscriber SSN	Co-Pay $

DENTAL INSURANCE INFORMATION

Primary Dental Insurance

Subscriber Name	Subscriber ID/Policy #	Group #	Subscriber DOB	Subscriber SSN

IN CASE OF EMERGENCY

Name of Friend or Relative	Relationship to Patient	Primary Number	Secondary Number

ADVANCE HEALTH DIRECTIVE

☐ I have a Living Will	☐ I have durable power of attorney for health	☐ I do not have living will or durable power of attorney	☐ I want more information about a living will

The above information is true to the best of my knowledge. I authorize assignment of benefits for services received to be paid directly to Brevard Health Alliance. I understand that I am financially responsible for any balance. I also authorize Brevard Health Alliance or my insurance company to release any information required to process my claims.

Signature:_____Date: _____

Demographic and Additional Information to better help us serve you:

Ethnicity	
	Hispanic or Latino
	Not Hispanic
Race (check all that apply)	
	Asian
	Native Hawaiian
	Other Pacific Islander
	Black/African American
	American Indian/ Alaska Native
	White
Primary Language	
	English
	Spanish
	Creole
	American Sign Language (ASL)
	Other Please Specify:
Do you identify yourself as (N/A if pediatric patient):	
	Straight or heterosexual
	Lesbian, gay or homosexual
	Bisexual
	Something else
	Other
What is your birth sex?	
	Female
	Male
I understand BHA may have students assisting with care?	
	Yes
	No
I understand BHA is my primary medical home?	
	Yes
	No
Are you a veteran?	
	Yes
	No

Education	
	Current Student
	Full Time
	Part Time
	N/A
Housing	
	Homeless
	Doubling Up
	Shelter
	Street
	Public Housing - HUD
	Rent
	Own
	Other _____
	Transitional
What is your current gender identity? (N/A if pediatric patient)	
	Female
	Male
	Transgender Male Female-to-Male
	Transgender Female Male-to-Female
	Gender neutral, neither exclusively male nor female
	Other
Employment Status	
	Full Time/ Part Time
	Migrant Worker
	Not Employed
	Seasonal
Marital / Relationship Status	
	Single
	Married
	Divorced
	Widowed
	Legally Separated
	Partner

All requested information is for statistical purposes only

Consent To Treat - HIPAA Consent - Other BHA Consents & Policies

PERSON(S) WHO MAY ACCOMPANY MINOR (OR ADULT) & MAKE DECISIONS FOR MEDICAL/DENTAL/ BEHAVIORAL TREATMENT

Name:	**Relationship:**	**Phone:**
1.		
2.		
3.		

PERSON(S) WHO MAY OBTAIN MY HEALTH INFORMATION FROM BHA - HIPAA Consent

Name:	**Relationship:**	**Phone:**
1.		
2.		
3.		

BHA Consents & Policies	**Initial Here**
CONSENT FOR TREATMENT: I, the undersigned, do consent for treatment as deemed necessary by my BHA health care provider. I, the undersigned, do also consent to treatment by BHA dental providers.	
ALL CHARGES ARE DUE AT THE TIME THAT SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO THE VISIT. I authorize ***Brevard Health Alliance*** to release any medical information necessary to process claims and further authorize payment of medical benefits payable directly to ***Brevard Health Alliance.*** I understand ***Brevard Health Alliance*** will file and complete the necessary steps to collect my insurance payment. However, if my insurance doesn't respond or payment is not made within 90 days, I understand that it is my responsibility to pay for any services rendered by ***Brevard Health Alliance.*** I further understand that ***Brevard Health Alliance*** may not be contracted with my insurance plan and I agree that I am responsible for charges denied for such reasons.	
Receipt of Our No Show Policy. I, the undersigned, do acknowledge receipt of the No Show Policy and will make every effort not to miss scheduled appointments, and will notify BHA within 24 hours of my scheduled appointment. If 2 no-shows occur within 6 months, you will need to walk-in and not be able to make a scheduled appointment. BHA Dental and Specialty appointments hold different no-show policies, please ask your BHA team member for further information.	
CONSENT FOR TREATMENT OF A MINOR. By signing this consent I represent that I have the legal responsibility for and authority to direct the medical treatment of the above patient, either as parent or legal guardian and I will hold harmless any attending physician or other person or entity against any claim that medical treatment provided to the above patient was not authorized. This consent includes this and subsequent office visits for which I bring this minor to this office. My permission also extends to releasing this medical record to consulting physicians if ever required to adequately diagnose and treat this minor.	
I consent for contact by telephone or text message or email for Appointment Reminders.	
Privacy Notice. I have been offered a copy of my rights to privacy of my protected health information.	
HIE Consent The Health First Health Information Exchange (HIE) grants clinicians participating in your care electronic access to your most up to date medical records. This consent is to establish if you would like to participate in the Health First HIE. (will be in effect until revoked by me in writing) Opt In: ☐ Opt Out: ☐	
Patient Rights & Responsibilities The Patient Bill of Rights is posted in the lobby. I acknowledge I may receive a copy of the Patient Bill of Rights upon request.	
FTCA Designation Brevard Health Alliance is an FTCA Deemed Facility. This health center receives HHS funding and has Federal Public Health Service (PHS) deemed status under 42 U.S.C. 233(g)-(n). With respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals. I understand this, and may request additional information upon request.	
After Hours and Emergency Care I acknowledge I have received a copy of the hours of operation for each clinic and the after-hours phone number for The Brevard Health Alliance, Inc. to reach an on-call provider in a medical emergency.	

By signing below and initialing on the above lines, I have read and understand the above.

Signature: _____ **Date:** _____

By signing below I acknowledge that I am an employee of Brevard Health Alliance and I have witnessed and can verify that the above signatures/initials are of the patient/patient representative.

Witness Signature: _____ **Date:** _____

Brevard HEALTH Alliance™

Sliding Fee Application & Financial Qualification Worksheet

Patient Name:_____

Date of Birth: _____ / _____ / _____

Home Phone: _____ Work Phone: _____

Employer/School:_____Occupation: _____

Is your employment seasonal? Yes No

Is your employment related to agriculture? Yes No

Financially Responsible Party (if not self): _____

Date of Birth: _____ Relationship to Patient:_____

Home Address: _____ City:_____State:_____Zip: _____

Home Phone: _____ Cell Phone:_____

Number of people in your household?_____ ***(This includes anyone who you could claim on your taxes)***

Name	Age	Relationship

Documented Proof of Income:	Current Monthly	Last 12 Months Total
Wages or Self Employment		
Social Security/Public Assistance		
Unemployment/Workers Comp		
Alimony/Child Support		
Pensions/Retirement Income		
Disability Income		
Any Other Income		
Total Annual Gross Income:		

I declare under penalty of perjury, under laws of the State of Florida, that all statements contained in this application and accompanying documents is true and correct, with full knowledge that all statements made in this application are subject to investigation and that any false or dishonest answer to any question may be grounds for denial of application.

I have read the Sliding Fee Application and I understand that payment is due at the time of services. If documentation of income verification is not given to BHA within **30 days** of this application, the application will no longer be valid and you must reapply. Thank you in advance for your cooperation.

No Proof and will submit in <30 days - self attested income: $_____

Signature: _____ Date: _____

For Office Use only:

Qualifies for Slide (circle one): A B C D E *F (No Discount/Full Fee)* Ineligible Date of Determination: _____

Signature of person making eligibility determination: _____

Sliding Fee Scale Explanation and Qualification Criteria - Family Size and Income

Sliding Fee Scale is base on the 2021 HHS Poverty Guidelines

Service Description	Slide A Homeless	Slide A 100% or Less	Slide B 101%-125%	Slide C 126%-150%	Slide D 151%-175%	Slide E 176%-200%	Slide F 201% +
Medical Services	$0	$10	$15	$25	$35	$50	Full Pay
Psychology Services	$0	$10	$15	$25	$35	$50	Full Pay
OB Service	$0	$10	$15	$25	$35	$50	Full Pay
Dental Services	$10	$20	$30	$40	$50	$60	Full Pay
Psychiatry Services	$0	$20	$30	$40	$50	$60	Full Pay
Pharmacy (Cost of Medications + Dispensing)	COM + $5	COM + $5	COM + $6	COM + $7	COM + $8	COM + $9	Full Pay

Sliding Fee Information

Thank you for selecting Brevard Health Alliance. Part of our mission for BHA is to provide quality services to you and your family. In doing so, BHA offers a sliding fee scale for patients and members of their families (as defined below) who fall below 200% of the poverty guidelines as set forth by the Federal Government. Income levels are based on total "family" income, family is defined below.

The amount of the discount and the income ranges for those discounts are set by BHA's Board of Directors and approved by the Federal Government. Income guidelines are revised annually. Current discounts and income guidelines are available at Brevard Health Alliance.

The sliding fee application will cover all medically necessary medical, behavioral, pharmacy, OB, and dental services. The costs of procedures, labs, tests, and provider visits that are deemed medically necessary, performed within a BHA clinic will qualify for the sliding fee discount. The costs of procedures, labs, tests and provider visits that are deemed optional, cosmetic or experimental will be the responsibility of the patient requesting the services at 100% of the regular rate charged. Even if services are ordered by a provider, it does not necessarily mean that they are medically necessary.

Definitions

Family-A family means those persons within the same household (including dependents/partner) who are applying for the sliding fee discount using their combined income.

Individual-An individual is a person 18 years old or over who has verifiable income using the list below (*).

Income Verification

Income is verified once a year. If a patient has a change in their income, it is their responsibility to notify BHA of that change. BHA reserves the right to verify income with an employer at any time. (*) Patients are required to provide at least two of the following items as verification of income.

1. Previous year tax return
2. Previous year W-2 form(s)
3. Current pay stubs (last 4 weeks, if possible)
4. Lay-off notification from last employer
5. Current information from unemployment office
6. Denied Medicaid application
7. Pay Stubs from unemployment (last 4, if possible)

If you were not required to file prior's years income tax return or you receive any of the following types of income, documentation must be submitted showing the amounts of each received by any member of the household.

1. Child Support
2. Welfare Assistance
3. Social Security
4. Unemployment
5. Self-Employment Income
6. Alimony
7. Retirement Income
8. Worker's Compensation
9. Disability Income
10. Any Other Income

Eligible Fees

Medical, Behavioral Health, Pharmacy, OB, and Dental Services that are provided at BHA are eligible for the sliding fee discounts. Deductibles and co-payments may be eligible for sliding fee discounts.

Minimum Charge

There is a minimum medical, mental health, pharmacy, OB, and dental charge for all sliding fee visits, as approved by the BHA Board of Directors. The minimum charge must be paid at the time of service regardless of insurance coverage.

Additional Information

Payment is required when services are rendered. Timeliness in completing this application is important.

Your application for the sliding fee discount will not be approved until complete documentation is received. Until you are approved for a sliding fee discount, you will be responsible for the full charges associated with services you receive from BHA unless any amounts are covered by other third party services. If you have any questions, BHA staff will assist you. Thank You!

*Please note that all patients, regardless of sliding fee requests, are asked to complete income information, as it is necessary for continued clinic funding; patients who are wanting a sliding fee must fill out form on page 4, along with the income information.

Thank you for your assistance!