Brookridge Internal Medicine Associates, PA

PLEASE BRING INSURANCE CARD, DRIVERS LICENSE AND MEDICATIONS TO YOUR APPOINTMENT.

PATIENT INFORMATION

Name_____ Date of Birth _____ Age_____
Address_____ City_____ State_____ Zip_____
Primary/cell phone# _____ Work #_____ Home # _____
Sex: M F SS # _____ Drivers License # _____

Ethnicity: ___Hispanic ___Not Hispanic Race: __White __African American ___Other

Last Primary Care Physician_____ Phone _____

Email address _____

EMPLOYER INFORMATION

Employer_____ Phone_____
Address_____ City_____ State_____ Zip_____
May we contact you at work? **Yes**_____ **No**_____

INSURANCE INFORMATION *(Must Be Filled Out To Bill Insurance Company)*

Insurance Company Name_____ Phone_____
Address_____ City_____ State_____ Zip_____
ID Number _____ Group # _____
Is Insurance with your employer _____Yes _____No
Subscriber Name_____ Date of Birth_____
Subscriber Address _____
Subscriber SS #_____ Phone_____
Employer_____ Phone_____

Secondary Insurance Information: (*Must Be Filled Out To Bill Insurance Company*)
Insurance Company Name _____
Subscriber Name _____ Subscriber SS#_____
ID Number _____ Group # _____ Subscriber DOB_____

EMERGENCY CONTACT

Name_____ Relationship_____ Phone_____
Address _____ City _____ State_____ Zip _____

Please be advised that you are ultimately responsible for the payment of services rendered to you. By signing below, you authorize direct payment of medical benefits to Brookridge Internal Medicine Associates, P.A. for services rendered and that you are financially responsible for any balance not covered by your insurance and for payment in full due to non-payment of health insurance premiums. Also, by signing below you authorize Brookridge Internal Medicine Associates, P.A. to release any medical or incidental information that may be necessary for either medical or processing applications for financial benefit.

X _____

SIGNATURE OF PATIENT/GUARDIAN **DATE**

NAME_____ **DOB**_____

PATIENT HEALTH HISTORY INFORMATION

PLEASE CIRCLIF IF **YOU** HAVE A HISTORY OF ANY OF THE FOLLOWING:

Arthritis	YES	NO	High Blood Pressure	YES	NO
Atrial Fibrillation	YES	NO	High Cholesterol	YES	NO
Congestive Heart Failure	YES	NO	Hypothyroid	YES	NO
Coronary Artery Disease	YES	NO	Prostate Enlargement	YES	NO
Diabetes	YES	NO	Pulmonary Embolism	YES	NO
Deep Vein Thrombosis	YES	NO	Seizures	YES	NO
GERD/ Reflux	YES	NO	Stroke	YES	NO
Heart Attack	YES	NO	Trouble Sleeping	YES	NO

Cancer: (Lung, Breast, Colon, Prostate, Etc.) YES NO DETAILS_____
Lung Disease: (Asthma, Emphysema, COPD) YES NO DETAILS_____
Psychiatric Illness: (Depression, Anxiety, Bipolar) YES NO DETAILS_____

Other Illnesses not listed above_____
_____
_____

Allergies_____

Medical Power of Attorney (person to make decisions if you can't)_____

Please List all Surgeries_____
_____

Current Medications (dosage and how taken): _____
_____
_____
_____

Marital Status: Married__ Single__ Divorced__ Separated __ Widowed__ Other_____

If Applicable: Gender Identity_____ Sexual Orientation_____

Do you currently smoke cigarettes? YES___NO___ Do you smoke Marijuana: YES__ NO__
Did you smoke in the past? YES__ NO___ If yes, number of years _____ number of packs per day____

Do you/did you drink alcohol? YES NO If yes how much_____ Quit date_____

Do you/did you ever use recreational drugs? YES NO If yes what kind_____ Quit date_____

FAMILY HISTORY	**YES**	**NO**	**FAMILY MEMBER**
Cancer			_____
Diabetes			_____
Hypertension			_____
Psychiatric Illness			_____

BROOKRIDGE INTERNAL MEDICINE ASSOCIATES, P.A.

HIPAA Written Acknowledgement of Privacy Practice

I acknowledge that Brookridge Internal Medicine Associates, PA has provided a written copy of the HIPAA Privacy Practice and I have been given the opportunity to read the Notice of Privacy Practices.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Brookridge Internal Medicine Associates, PA to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). **(Brookridge Internal Medicine Associates, PA's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)**

I have the right to review the Notice of Privacy Practices prior to signing this consent. Brookridge Internal Medicine Associates, PA reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Brookridge Internal Medicine Associates, PA's Privacy Officer at 300 N. 3rd St., Longview, Tx. 75601.

With this consent, Brookridge Internal Medicine Associates, PA may call my home or other alternate 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 results among others.

With this consent, Brookridge Internal Medicine Associates, PA may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Brookridge Internal Medicine Associates, PA may e-mail to my home or other alternative location 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 Brookridge Internal Medicine Associates, PA restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Brookridge Internal Medicine Associates, PA's use and disclosure of 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. If I do not sign this consent, or later revoke it, Brookridge Internal Medicine Associates, PA may decline to provide treatment to me.

I give consent for Brookridge Internal Medicine Associates, PA to give my Protected Health Information to persons listed below (these are people outside of your additional medical providers):

_____

_____

_____ _____

Signature of Patient or Legal Guardian Date

_____

Patient's name (printed)

Brookridge
INTERNAL MEDICINE
Associates, P.A.

MEDICAL AUTHORIZATION TO SEE NURSE PRACTITIONER

I hereby accept medical treatment at Brookridge Internal Medicine Associates, P.A. by a Nurse Practitioner. It has been explained that they are not medical doctors but are licensed by the State of Texas. I understand that the Supervising Physician is Dr. Brenda Vozza and any problems with my medical care/treatment may be discussed with her. The medical treatment will be provided in accordance with the rules and regulations provided by the Texas State Board of Medical Examiners. Furthermore, treatment will be provided in accordance with the Protocols and Policies and Procedures as established by Dr. Brenda Vozza.

I am also aware that at any time I can request to see Dr. Vozza to carry out my medical treatment or answer questions about my medical care.

Patient's Name_____

Signature of Patient or Guardian_____

Date:_____ Witness: _____

Brookridge
INTERNAL MEDICINE
Associates, P.A.

TELEMEDICINE CONSENT

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting Brookridge Internal Medicine Associates, PA at (903) 315-2907.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

Patient/Parent/Guardian Printed Name	Patient/Parent/Guardian Signature
Witness Signature	Date

Brookridge Internal Medicine Associates, PA

E-Prescribing PBM Consent Form

Patient Name: _____ Date of Birth _____

Your Pharmacy:_____

EPrescribing or Electronic Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribing program. These include:

* **Formulary and benefit transactions**-- Gives the prescriber information about which drugs are covered by the drug benefit plan.
* **Medication history transactions**-- Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form you are agreeing that Brookridge Internal Medicine Associates, PA can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefits for treatment purposes.

Signature of Patient (or representative)_____

Relationship if other than patient_____

Date _____

Brookridge Internal Medicine Associates

PATIENT CONSENT TO PATIENT PORTAL COMMUNICATIONS

Brookridge Internal Medicine Associates, PA or BIM offers an electronic Patient Portal which allows you to electronically provide us with your health information for purposes such as registering for an appointment and allows us to electronically provide you with information such as test results and other medical reports. If you would like to use the Patient Portal, please review this form and acknowledge your consent by signing and returning this form to us. Use of the Patient Portal is strictly voluntary, and you are under no obligation to sign this form if you do not wish to use the Patient Portal.

DO NOT USE THE PATIENT PORTAL IF IT IS AN EMERGENCY OF YOU WISH TO COMMUNICATE SENSITIVE HEALTH INFORMATION (HIV/AIDS, MENTAL HEALTH, GENETIC INFORMATION). IF AN EMERGENCY, CALL 911.

1. OUR RESPONSIBILITY REGARDING THE PATIENT PORTAL

- We will only use or disclose your protected health information maintained in the Patient Portal as specified in our Notice of Privacy Practices and as set forth in this Consent.
- We will take measures that we believe to be reasonable and appropriate to protect the security of all Patient Portal communications. These measures include administrative, physical and technical safeguards of your electronic protected health information. However, we shall be under no obligations to encrypt communications from our office.
- We will retain copies of all Patient Portal communications from you and to you.
- We reserve the right to suspend or terminate the Patient Portal at any time for any reason. We will notify you if this occurs.
- Upon receipt of the Consent, we will contact you with instructions to register for use of the Patient Portal.

2. YOUR RESPONSIBILITY REGARDING PATIENT PORTAL COMMUNICATIONS

- If the reason you wish to contact us concerns a matter requiring immediate attention, or, if you are uncertain whether it may be an urgent matter, you must call our office at 903-315-2907 instead of communicating with us by the Patient Portal.
- Understand that information you submit through the Patient Portal may not be read immediately during regular office hours when other patients are being seen or when our office is closed;, therefore, you must contact us via telephone or through our answering service regarding any issue that may require more immediate attention.
- Include how we may contact you in the text of our Patient Portal message.
- Keep you Patient Portal user name and password secure at all times and do not share your Patient Portal user name and password with anyone. You are responsible for the protection of your user name and password. Brookridge Internal Medicine Associates, PA shall not be liable for the protection of such information.
- Be as concise as possible in your Patient Portal messages. The Patient Portal may not be an appropriate method to communicate and received specialized medical or treatment advice. We may contact you by telephone, or we may request that you schedule an appointment for an office visit if we determine from a Patient Portal message that you require more personal contact or a detailed follow up.
- Provide us with and keep up-to-date, the email address to which you would like us to send notifications/ messages sent via the Patient Portal.
- Understand that your internet service and network providers may be able to access portal messages sent over your system, and that portal messages sent to us may be intercepted or viewed in transmission by person(s) unknown to you or us.
- Understand that because of technical failures inherent in electronic communications, it is your obligation to contact us by another method (via telephone, answering service, etc.) if we have not responded within three (3) business days to any electronic Patient Portal message you have sent to us.

My signature below acknowledges that I have read and understand the information contained in this Consent form and that I consent to electronic communications through the Patient Portal with personnel of BIM. I understand that such electronic portal communications may contain medical information about me and concern matters regarding my health care. I have reviewed and agree to fulfill my responsibilities as detailed in Section 2 above. I authorize BIM's personnel to respond to Patient Portal communications that BIM personnel reasonably believe to be from me. I understand that Patient Portal communications are subject to inherent risks of inadvertent and unintentional disclosure of my confidential health information and personally accept the risks of such disclosures in exchange for BIM's willingness to comply with my request to use the Patient Portal as a non-exclusive form of communications to and from BIM's practice. Further, in consideration for the promises detailed above in Section 1 of the Consent. I agree to hold harmless BIM, its physicians, officers, employees, agents, affiliates, and insurers from any and all claims, causes of action, losses, injuries, liabilities and expenses arising out of or relating to any electronic mail technical or administrative failure(s) and unauthorized disclosures.

This service is being offered to you at no charge but BIM reserves the right to change that policy at any time with prior notice to you. Likewise, BIM reserves the right to add or delete features of the Patient Portal at any time with prior notice to you. Refusal to sign this Consent will not affect our treatment of you nor in any way affect your eligibility for benefits of the services covered by your health plan. You may revoke this Consent and discontinue use of the Patient Portal by providing Brookridge Internal Medicine Associates, PA written notice.

_____ _____

SIGNATURE DATE

_____ _____

PRINTED NAME E-MAIL ADDRESS

BROOKRIDGE INTERNAL MEDICINE ASSOCIATES, PA

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. I authorize the use and disclosure of information from the medical record of:

Patient Name _____ Date of Birth _____

Address _____

Phone# _____ SSN _____

2. I authorize the following individual organization to disclose the above-named individual's health information:

Name _____

Address _____

Phone # _____ Fax# _____

This information may be disclosed TO and used by Brookridge Internal Medicine Associates, P.A., 300 N. Third St., Longview, TX 75601. Phone (903)-315-2907 Fax (903) 722-9013 for the purpose of medical care.

3. The type and amount of information to be disclosed is as follows: (*specify dates where appropriate):*

__ Most recent 3 years
__ All records
__ Mammogram
__ Other _____

_ Immunizations
_ X-Ray Reports
_ HIV testing

_ Laboratory Results
_ Colonoscopy
_ Last Eye Exam

4. I understand that the medical information released by this authorization may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also, include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

___**YES,** I consent to the release of this information ___**NO,** I do not consent to the release of this information

5. I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

6. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition _____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information. I can contact the privacy office at 903-315-2907.

_____ _____
Signature of Patient or Authorized Personal Representative Date

_____ _____
Personal Representative's Name (print) and Relationship Date

TEXAS Health and Human Services | Texas Department of State Health Services

TEXAS IMMUNIZATION REGISTRY (ImmTrac2)
ADULT CONSENT FORM

(Please print clearly)

First Name _____ Middle Name _____ Last Name _____

Date of Birth (mm/dd/yyyy) ____/____/____ Gender: ☐ Female ☐ Male Telephone ___-___-____ Email address _____

Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Recipient Refused

The Texas Immunization Registry is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). With your consent, your immunization information will be included in ImmTrac2.

For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation for that minor by completing the ImmTrac2 Minor Consent Form (# C-7) available for downloading at www.ImmTrac.com.

Consent for Registration and Release of Immunization Records to Authorized Persons / Entities

I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the Texas Immunization Registry. Once in ImmTrac2, my immunization information may by law be accessed by: a Texas physician, or other health care provider legally authorized to administer vaccines, for treatment of the individual as a patient; a Texas school in which the individual is enrolled; a Texas public health district or local health department, for public health purposes within their areas of jurisdiction; a state agency having legal custody of the individual; a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy. **I understand that I may withdraw this consent at any time.**

State law permits the inclusion of immunization records for First Responders and their immediate family members (older than 18 years of age) in the Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation as an "ImmTrac2 child" by completing the Immunization Registry (ImmTrac2) Consent Form (# C-7).

Please mark the appropriate box to indicate whether you are a First Responder or an Immediate Family Member.

☐ I am a FIRST RESPONDER. ☐ I am an IMMEDIATE FAMILY MEMBER (older than 18 years of age) of a First Responder.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas immunization registry.

Individual (or individual's legally authorized representative): _____ Printed Name

_____ Date _____ Signature

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.texas.gov for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac Group • MC 1946 • P. O. Box 149347 • **Austin, TX 78714-9347**

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and affirm that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**

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