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Complete Intake Form for Medicare Pts

Checklist of items to bring to your first visit:

1. Registration forms
2. Photo ID
3. List of your current medications and dosages
4. Previous medical records from doctors, hospitals, if applicable

Important Information about our practice:

Regular office hours: Monday through Thursday from 9:00AM to 4:00PM unless prior arrangements are made. Please call during these hours for all routine matters such as appointments, prescription refills, referrals and general questions.

Telephone calls during office hours:

When calling the office, always call the same number: 845-241-0040. There may be times when you may need to leave a message for a call back.

Prescription refills:

The best way to get prescriptions refilled is to send a text message or use the REFILL REQUEST button on the website: www.bravourewellness.com.

Test results:

When diagnostic testing or labs are ordered, you will be scheduled to discuss the results, or we will coordinate a time to discuss those results. We will alert you if an emergent problem is detected.

BRAVOURE

Complete Intake Form for Medicare Pts

Appointments:

Appointments can be made by phone or you can use the online booking option through our secure website: www.bravourewellness.com. Appointments made online will remain tentative until confirmed by our staff.

Appointment cancelations are a part of life but we would appreciate at least 24 hours notice.

Forms:

Prior authorization forms and other forms will be completed by our office over 5-7 business days. Please allow sufficient time if you require forms to be completed. Please provide all of the necessary forms required to be completed so that all of the information can be addressed during your visit.

Communication Via E-mail and Patient Portal messaging, Text messaging:

Limit email content to non-urgent medical questions and matters. Please do not use email or the patient portal to communicate urgent situations. If an urgent situation occurs, please contact the office by phone. If you are experiencing a medical emergency, dial 911 or go to the nearest Emergency Department. Although we will attempt to reply to your messages and emails as quickly as possible, it may take more than one business day. In some cases we may call you by phone directly rather than respond by text or email. Emails intended for discussion of symptoms, clinical questions or therapy adjustment with communication between you and your doctor over a period of several days are considered an E-Visit. These may be subject to additional fees if you are not enrolled in our membership plan.

Controlled Substance Prescriptions:

Controlled substances such as narcotics will be prescribed only if your doctor considers them as indicated and necessary.

BRAVOURE

Complete Intake Form for Medicare Pts

Code of Conduct:

For the health and safety of all patients and staff of Integrated Rheumatology Care we expect to treat each other with dignity and respect and adhere to the following: • Respect other patients' right to privacy, which is protected by federal law. • Violent, aggressive, and/or inappropriate behaviors are not permitted and will not be tolerated. Any verbal and/or physical threats or actions against staff and/or other patients will be grounds for discharge from our practice. • Sexual misconduct, including sexual assault, harassment, exploitation, or intimidation of staff and/or patients, or unwelcome behaviors of a sexual nature is grounds for discharge from our practice. • Personal belongings and valuables are the responsibility of the individual patient. Our practice will not be responsible for any lost or missing items. • Weapons, recreational drugs, alcohol and smoking are not permitted in our office. • During Telehealth visits (also called telemedicine), patients should be in a private location where they can speak freely about their health, patients should be fully dressed for their video visits and cannot be driving or walking on the street during these visits.

Name (print): _____

Signature _____

Date _____

BRAVOURE

Complete Intake Form for Medicare Pts

Patient Demographics Form:

Full name: _____

Date of birth: _____

Primary phone: _____ Home mobile (please circle one)

Secondary phone: _____ Home mobile work (please circle one)

Email: _____

Address: _____

_____

Emergency Contact:_____

Relationship to patient: _____

Phone number: _____

Email address:_____

Address: _____

Preferred Pharmacy:

Name: _____

Address: _____

Phone number: _____

Please take the time to fill out this form. This information will help the provider get ready for your visit.

BRAVOURE

Complete Intake Form for Medicare Pts

Name of your primary care provider: _____

How did you learn of Bravoure Medical Wellness?_____

What is the reason for your visit? _____

_____

Review of Systems: Please circle if you are experiencing any of the following:

Fatigue
Weakness of a limb
Fever
Abdominal pain
Night sweats
Constipation
Weight loss
Diarrhea
Weight gain
Heartburn
Nausea/Vomiting
Dry eyes
Blurred vision/double vision
Redness in the eyes
Vision loss
Jaundice
Foamy urine

Change in the color of your urine
Blood in urine
Painful urination
Difficulty with urination
Waking up at night to pass urine
Hearing loss
Ringing in ears
Loss of smell
Nosebleeds
Nose sores
Mouth sores
Skin ulcers
Skin rashes
Itchy skin
Difficulty swallowing
Hoarseness of voice
Cough

Shortness of breath
Coughing up blood
Wheezing
Snoring/sleep apnea
Chest pain
Irregular heartbeat/palpitations
Shortness of breath at night
Muscle pain
Morning stiffness
Joint pain/Joint swelling
Neck pain
Back pain
Headaches
Difficulty with balance/vertigo
Depression
Anxiety
Numbness/Tingling of a limb

BRAVOURE

Complete Intake Form for Medicare Pts

Health Maintenance Questionnaire: Please complete if applicable for age/gender:

Have you have had a chest x-ray over the last year? Yes No (please circle one)

Date of last mammogram (women age 40 and older): _____

Date of your last bone density test (DEXA) (post-menopausal women and men older than 70 years): _____

Date last colonoscopy (patients 45 and older): _____

Date of last eye exam: _____

Procedures/Surgical History: Please circle if you have had any of the following surgeries/ procedures:

Angioplasty/Cardiac Stents

Cardiac bypass surgery

Cardiac pacemaker placement

Carpal Tunnel Surgery

Hernia Repair

Hip replacement

Knee replacement

Back surgery

Neck surgery

Appendectomy

Spleen removal

Gallbladder removal (cholecystectomy)

Blood transfusion

Tonsillectomy

Thyroid surgery

Fracture repair

Cataract extraction

Hysterectomy with or without ovary removal

C-section Chemotherapy

Radiation

Bariatric surgery
(gastric bypass or sleeve, lap band)

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Complete Intake Form for Medicare Pts

Gynecologic history (women only):

Date of last menstrual period: _____

Currently using birth control: yes no

If using birth control, what are you using? _____

Last pap smear: _____

History of abnormal pap smear: yes no (please circle)

Number of pregnancies:_____

Number of miscarriages/pregnancy losses: _____

Social History: Please check if you have a history of any of the following:

☐ Current tobacco use (cigarette, cigar, pipe, chewing tobacco, smokeless tobacco, vape)

☐ Former tobacco use

☐ Never used tobacco

☐ Alcohol daily use > 2 drinks per day

☐ Caffeine > 2 cups per day

☐ Marijuana use – medicinal or recreational

☐ Recreational drug use (cocaine, etc.)

☐ Opioid abuse/dependence

Marital Status: Circle one

Never married Married Divorced Separated Widowed

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Complete Intake Form for Medicare Pts

Occupation (type of work): _____

Immunization history:

☐ Flu vaccine ☐ Pneumonia vaccine ☐ Zoster/shingles vaccine ☐ Covid-19 vaccine

Medication allergies: Please list below

_____

_____

What is your most recent height and weight?

Weight: _____

Height: _____

Continued on next page

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Complete Intake Form for Medicare Pts

HIPPA - Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. Getting an electronic or paper copy of your medical record:

• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

• We will provide a copy or a summary of your health information. We may charge a reasonable cost-based fee if you require a full copy of your records. Ask us to correct your medical record.

• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

• We may say “no” to your request, but we’ll tell you why in writing within 60 days. Request confidential communications.

• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

• We will say “yes” to all reasonable requests. Ask us to limit what we use or share.

• You can ask us not to use or share certain health information for treatment, payment, or our operations.

• We are not required to agree to your request, and we may say “no” if it would affect your care.

• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.

• We will say “yes” unless a law requires us to share that information. Get a list of those with whom we’ve shared information.

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Complete Intake Form for Medicare Pts

• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. Get a copy of this privacy notice.

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. Choose someone to act for you.
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action. File a complaint if you feel your rights have been violated.
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1- 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

• We will not retaliate against you for filing a complaint.

YOUR CHOICES: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

• Share information with your family, close friends, or others involved in your care

• Share information in a disaster relief situation

• Include your information in a hospital directory

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Complete Intake Form for Medicare Pts

• Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In the following cases we never share your information unless you give us written permission:

• Marketing purposes

• Sale of your information

In the case of fundraising: • We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR RESPONSIBILITIES: We are required by law to maintain the privacy and security of your protected health information.

We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

Effective Date of Notice (Today's Date):

Please sign your name:_____

Date: _____

Continued on next page

BRAVOURE

Complete Intake Form for Medicare Pts

HIPAA Compliance – Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication.

You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

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 privacy 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 revoke 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.

May we call/phone, email or send a text to you to confirm your appointments? Yes No

May we leave a message on your answering machine at home or on your cell phone? Yes No

May we discuss your medical condition with any member of your family? Yes No

If YES, please name the members allowed:_____

_____

Print your full name: _____

Date: _____

Please sign your name:_____

BRAVOURE

Complete Intake Form for Medicare Pts

Consent for Treatment

I give permission to Christine S. Carter, Family Health Nurse Practitioner, PLLC. (DBA Bravoure Medical Wellness) to give me medical treatment.

I understand Christine S. Carter, Family Health Nurse Practitioner, PLLC. (DBA Bravoure Medical Wellness) is a private practice and out of network with commercial and federal insurance companies (Medicare and Medicaid) and will not bill my insurance benefits to pay for the care I receive.

I understand that:

- I must pay in full for the cost of the service prior to the service being rendered.
- If I have a commercial insurance plan, I may submit for reimbursement if my insurance participates in out of network benefits.
- The amount of reimbursement by a commercial insurance company may not be equivalent to the full cost of the service billed by Christine S. Carter, Family Health Nurse Practitioner, PLLC. (DBA Bravoure Medical Wellness).
- If I am a Medicare patient, I cannot seek reimbursement from Medicare/CMS at any time as my medical provider has opted out of Medicare and I have voluntarily signed a private contract with Christine S. Carter, Family Health Nurse Practitioner, PLLC. (DBA Bravoure Medical Wellness)

I understand that:

I have the right to refuse any procedure or treatment.

I have the right to discuss all medical treatments with my clinician.

Full Name: _____

Signature:_____

BRAVOURE

Complete Intake Form for Medicare Pts

INFORMED CONSENT FOR TELEMEDICINE SERVICES

INTRODUCTION

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: • Patient medical records • Medical images • Live two-way audio and video

- Output data from medical devices and sound and video files Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error.

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BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent,
- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,
- I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee,
- I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time Christine Carter, DNP, FNP-C has explained the alternatives to my satisfaction,
- I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
- I understand that it is my duty to inform Christine Carter, DNP, FNP-C of electronic interactions regarding my care that I may have with other healthcare providers.
- I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
- I attest that I am located in the state of New York and will be present in the state of New York during all telehealth encounters with Christine Carter, DNP, FNP-C

PATIENT CONSENT TO THE USE OF TELEMEDICINE: I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care. I understand a copy of this form will be available for me. I hereby authorize Christine Carter, DNP, FNP-C to use telemedicine in the course of my diagnosis and treatment.

Please sign your name: X_____

Date: _____