brio
PRIMARY CARE
with MUSC Health

New Patient Packet

Patient Information

First Name _____ Last Name _____ Middle Initial _____

Preferred Name _____ Date of Birth _____ Social Security Number _____ Preferred Language _____

Race / Ethnicity _____ Hispanic Origin? Yes ☐ No ☐ Gender Assigned at Birth: Male ☐ Female ☐

Preferred Pronouns: He / Him / His ☐ She / Her/ Hers ☐ They / Them / Theirs ☐ Other: ☐

Street _____ City / State _____ Zip Code _____

Cell Phone _____ Home Phone _____ Email Address _____

Primary Insurance Information

Insurance Company _____ Claim Address on Back of Card _____ Subscriber Name & Middle Initial _____

Subscriber Date of Birth _____ Subscriber / Member ID Number _____ Group Number _____

Secondary Insurance Information

Insurance Company _____ Claim Address on Back of Card _____ Subscriber Name & Middle Initial _____

Subscriber Date of Birth _____ Subscriber / Member ID Number _____ Group Number _____

Emergency Contact

Full Name _____ Phone Number _____ Relationship to Patient _____

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First Name	Last Name	Date of Birth

Medical History

Social History

Please check the box "No" or "Yes" for the questions below. If you would like to add more detail, please leave comments in the "Explain" column.

	No	Yes	Explain
Do you currently smoke or use tobacco products? *If yes, how many per day?*			
Have you smoked or used tobacco products in the past? *If yes, how many times per day, and how many years did you smoke?*			
Do you drink caffeinated beverages? *If yes, what type and how often / much?*			
Do you drink alcohol? *If yes, what type?*			
Do you exercise regularly? *If yes, what type, how often, and how long?*			

Surgical & Hospitalization History

Please list all hospital admissions and operations below.

Hospitalization / Surgery	Year

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Allergies

Please list all medical, environmental, and other allergies below.

_____

_____

Medications

Please list all medications you are currently taking.

Medication Name *Example: Adderall*	**Dosage** *Example: 10 mg*	**Frequency** *Example: Once / Day*

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Personal Medical History

Please check the box "Yes" if the below applies to your personal medical history, otherwise leave blank. If you would like to add more detail, please leave comments in the "Explain" column.

Personal Medical History	Yes	Explain
Allergies		
Asthma		
COPD		
Anxiety		
Depression		
Bipolar Disorder		
Diverticulitis		
Reflux / Heartburn		
Irritable Bowel Syndrome		
Psoriasis		
Eczema		
Anemia		
Clotting Disorder		
Thyroid Dysfunction		
Stroke		
Seizures		
Headaches		
Migraines		
Diabetes		
High Blood Pressure		
High Cholesterol		
Osteoporosis		
Osteoarthritis		
Rheumatoid Arthritis		
Heart Disease		
Kidney Disease		
Liver Disease		
Sinus Disease		
Cancer		
Menopause		

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_____	_____	_____

Preventive Care

Please list the date of your most recent procedures and immunizations. Please write "N/A" if not applicable.

Procedure / Immunization	**Year** *(include month and day if known)*
Pap Smear	_____
Mammogram	_____
Bone Density	_____
Colonoscopy	_____
Tdap	_____
PCV20 (Pneumonia Vaccine)	_____
Gardasil	_____

Current Symptoms

Please check any symptoms you have had recently.

- ☐ Abdominal Pain
- ☐ Anxiety
- ☐ Black Stools
- ☐ Blackouts
- ☐ Blood in Urine
- ☐ Blood in Stools
- ☐ Blurred Vision
- ☐ Breast Change / Discharge
- ☐ Chest Pain
- ☐ Constipation
- ☐ Cough / Sputum
- ☐ Depression
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Difficulty Voiding
- ☐ Dizziness
- ☐ Double Vision
- ☐ Easy Bruising
- ☐ Excessive Fatigue
- ☐ Fever / Chills
- ☐ Glasses / Contacts
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Hot Flashes
- ☐ Insomnia
- ☐ Joint Pain / Swelling
- ☐ Leg Swelling
- ☐ Loss of Appetite
- ☐ Loss of Balance
- ☐ Menstrual Changes
- ☐ Nausea
- ☐ Night Sweats
- ☐ Painful Urination
- ☐ Palpitations
- ☐ Prolonged Numbness
- ☐ Rashes / Mole Changes
- ☐ Ringing in Ears
- ☐ Seizures
- ☐ Severe Heartburn
- ☐ Sexual Problems
- ☐ Shortness of Breath
- ☐ Significant Weight Loss / Gain
- ☐ Sinus Drainage
- ☐ Sore Throat
- ☐ Tremor
- ☐ Vomiting
- ☐ Wheezing

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_____ _____ _____
First Name Last Name Date of Birth

Preferred Pharmacy

Pharmacy Name: _____

Pharmacy Address / Phone Number: _____

Family Medical History

If any of your family members have had the below medical conditions, please list their relation to you and any additional details you find necessary. If not applicable, please leave blank.

	Family Member & Details
Allergies	
Alzheimer's Disease	
Asthma	
Bleeding / Blood Clotting Disorder	
Cancer	
Diabetes	
Heart Disease	
High Blood Pressure	
High Cholesterol	
Migraines	
Osteoporosis	
Psychiatric Disorder / Mental Illness	
Seizures / Convulsions	
Stroke	
Thyroid Problems	
Other	

Please list any other medical history you consider important to share.

_____

_____

How did you hear about Brio?

Patient Referral ☐ Insurance Referral ☐ Physician Referral ☐
Google / Internet ☐ Social Media (our Website, Instagram, Facebook) ☐

Other: _____

HIPAA Disclosure

First Name	Last Name	Date of Birth

The Brio Primary Care HIPAA Notice of Privacy Practices

can be found at www.brioprimarycare.com on our "Current Patients" page under "Patient Forms"

or through the link below.

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I certify that I have reviewed and/or received a copy of the Brio Primary Care Notice of Privacy Practices. I understand that the uses and disclosures of my personal health information are described in the Notice of Privacy Practices received. Possible disclosures include, but are not limited to, disclosure to another health care provider or Health Information Exchanges (HIE) for treatment, process of payment, or Brio Primary Care operations. See the attached Notice of Privacy Practices for additional possible disclosures and instructions on how to limit my participation in HIE or to whom my health information is disclosed.

Patient / Legal Representative Name	Relation to Patient
Patient / Legal Representative Signature	Date Completed

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First Name	Last Name	Date of Birth

Practice Policies

We are committed to providing our patients with the best service at every visit. In return, we ask that you please read and adhere to the following policies, which pertain to services rendered at Brio Primary Care.

Late Arrival Policy
We all run late sometimes! If you find yourself running late for an appointment, please call to let us know as soon as you can. In most cases, it may be best for both you and the practice to reschedule the appointment to ensure the best care. We will do our best to still see you, but if you arrive late for your appointment, please expect longer wait times as we accommodate those patients who have arrived on time.

Appointment Cancelation Policy
If you need to cancel your appointment, please call us at least **24 hours** in advance. Your appointment will be rescheduled at no cost. If you cancel within 24 hours of your scheduled appointment, a *$25 fee* will be applied to your account.

Missed Appointment Policy
A visit is considered a "missed appointment" when it is not canceled in advance and/or the patient does not show up for his/her appointment. Our policy varies whether you are a new or existing patient.

- **New Patient** - A *$100 fee* will be added to your account if you fail to arrive for your initial visit. To reschedule your New Patient appointment, you must pay the *$100 fee*. Should the rescheduled New Patient appointment be missed a second time, you will be charged another *$100 fee*. Additionally, you will be considered discharged from the practice, and unable to establish care at Brio Primary Care.
- **Existing Patients** - A *$50 fee* will be added to your account for each missed appointment. Three missed appointments within a 12-month period will result in discharge from Brio Primary Care.

*Medicaid beneficiaries cannot be charged for missed appointments. A missed appointment is not a distinct reimbursable Medicaid service but a part of the provider's overall costs of doing business. The Medicaid rate covers the cost of doing business, and Providers may not impose separate charges on beneficiaries.

Discharge Policy
In the event of a discharge from Brio Primary Care, you will receive a notification that you have 30 days to find alternative medical care; subject to practice specific exceptions pertaining to emergencies, medication refills, etc., which will be communicated in your discharge notice.

Referrals Policy
Our Referrals Department will follow up with the specialist's office. The referral will be closed if it is not fulfilled within 12 months. Once the referral is closed, an office visit will be required to receive a new referral.

Ambulatory Consent for Medical Treatment
I, _____, (as a patient, parent, guardian, spouse, guarantor, or other responsible party), consent to and authorize medical treatment and diagnostic procedures which may be ordered and/or provided by and performed at Brio Primary Care. I understand that this consent for medical treatment, assignment of insurance benefits, and agreement of financial responsibility will be valid for one year from the date of signature and can only be revoked upon written notice.

Patient / Legal Representative of Patient Name	Relation to Patient
Patient / Legal Representative of Patient Signature	Date Completed

PRIMARY CARE
with MUSC Health

First Name _____ Last Name _____ Date of Birth _____

Payment Policies

We are committed to providing our patients with the best service at every visit. In return, we ask that you please read and adhere to the following policies, which pertain to services rendered at Brio Primary Care.

Proof of Insurance
We participate in most insurance plans. It is your responsibility to confirm whether or not Brio Primary Care is in network with your specific insurance plan. If you are not insured by a plan we do business with or you do not have insurance, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment plan in full for each visit is required until we can verify your coverage.

Co Payments and Balances
If applicable, all co pays and outstanding account balances must be paid at the time of each visit.

Claims Submissions
As a courtesy, we will submit your claims to your insurance provider following each visit to our practice. After processing with your insurance provider, we will send you a billing statement from Brio Primary Care for any remaining uncovered charges. We ask that you provide payment in full for all services or create a payment plan immediately upon receipt of each billing statement.

Non-Covered Services
Please be aware that some, and perhaps all the services you receive may be non-covered and/or not considered reasonable or necessary by your insurance provider. Since insurance plans vary, please contact your insurance provider for detailed information about what is covered or not covered, including, but not limited to preventive maintenance, immunizations, after hours fees, etc. You will be responsible for all non-covered services.

If labs are not covered by insurance, you will receive a bill from Brio Primary Care with MUSC Health, Labcorp, and/or both entities. Please note, you will receive a discount for any bills you may receive from Brio Primary Care for labs that are not covered by insurance (this does not include invoices from Labcorp).

Partial Payments
Partial payments will not be accepted unless otherwise negotiated with our Billing Department.

Self Pay
A discount will be given to patients who elect to be self pay for services and who will not be submitting the claim to an insurance carrier. This discount will be automatically applied to claims and will be factored in to estimates. The self pay discount only applies to services provided by Brio Primary Care. You may receive a separate bill from a non-Brio Primary Care provider (i.e. lab services, medical equipment, etc.). You are financially responsible for all additional services.

A deposit of $100 must be paid on the date of service. Charges for services rendered are an estimate until final coding of the claim(s). Additional charges may be applied, and you may receive a bill for additional services owed beyond your $100 deposit. You have the right to receive a Good Faith Estimate that estimates the cost of your medical care. Please contact our Billing Department at 864-720-1400 to receive this estimate for any future appointments.

Non-Payment Due
Please be aware that if your account goes unpaid thirty (30) days past the due date, we may refer your account to a collection agency. At the time of referral to a collection agency, you will be discharged as a patient from Brio Primary Care. Should this unfortunate circumstance occur, you will be responsible for any collection or legal costs associated with collecting on your account. We understand that everyone's situation is unique and financial hardships may occur. Please contact our Billing Department at 864-720-1400 should you find yourself in a hardship position and we will do our best to work with you to the extent we are able.

Forms of Payments
The practice accepts payments by Visa, MasterCard, American Express, Discover and debit cards bearing these logos at the front desk. Checks and money orders will be accepted by mail and online payments can be made with Visa, MasterCard, American Express, Discover and debit cards bearing these logos.

_____ _____
Patient / Legal Representative of Patient Name Relation to Patient

_____ _____
Patient / Legal Representative of Patient Signature Date Completed

Patient Privacy Form

Patient Information

_____ _____ _____

First Name Last Name Date of Birth

_____

Email Address

Activate my patient portal using this email address ☐ Yes ☐ No

I prefer to receive paper statements instead of email statements ☐ Yes ☐ No

Office Policy: To ensure your privacy and the privacy of other patients during your visits, photography, videography, and/or other audio recordings are strictly forbidden on the premises, unless express permission is otherwise granted by a Team Member of Brio Primary Care.

Sharing Information and Access

Please check the information below that you authorize Brio Primary Care to give out for the above patient and list who has permission to receive this information or access other than the patient.

☐ Lab / X-Ray Results ☐ Appointment Information ☐ Billing Information ☐ Medical Information

☐ Schedule an Appointment on My Behalf ☐ Make Payments on my Behalf ☐ Proxy Access to My Online Portal

_____ _____

First and Last Name Relationship to Patient

_____ _____

First and Last Name Relationship to Patient

Communication Preferences

Brio will only contact you regarding appointment reminders, medical services, billing, or matters related to medical care.

I authorize Brio Primary Care to:

☐ Email me about Brio Aesthetics specials, offers, and updates

☐ Send me important updates via SMS/Text *(message & data rates may apply)* at _____

☐ Leave a message regarding all information including appointments, general information updates, billing, etc.

☐ ***OR*** appointment information only on the following voicemail(s):

Primary Number: _____ Phone Call Recipient: _____

Secondary Number: _____ Phone Call Recipient: _____

Rights of the Patient: I understand that I have the right to revoke this authorization at any time by sending notification to Brio Primary Care, 2 Bella Grove Drive, Greenville, SC 29607. I understand that revocation is not effective in cases where the information has already been used or disclosed, but will be effective going forward. I understand that information used or disclosed as a result of this authorization may result in re-disclosure by the recipient and may no longer be protected by federal or state law. Information received by this office is for our own use and will continue to be protected by our Privacy Policy. I understand that I have the right to inspect or copy the protected health information disclosed as described in this document. I can do this by written notification to Brio Primary Care, 2 Bella Grove Drive, Greenville, SC 29607. I understand that I have the right to refuse to sign this authorization.

_____ _____

Patient Signature Date Completed

Medical Records Release Form

Transfer to Brio

This authorization form must be **COMPLETED** in its entirety in order to be considered valid.

I give permission to release the health information of:

Patient First Name	Patient Last Name	Patient Date of Birth

Patient Address *(Street, City, State, Zip Code)*

Last 4 of Social Security Number	Email Address	Phone Number

Release Records From

Name of Facility / Location of Office	Name of Provider

Address *(Street, City, State, Zip Code)*

Phone Number	Fax Number

Release Records To

Brio Primary Care
Name of Facility

2 Bella Grove Drive, Greenville, SC 29607
Address

864-603-5600	864-603-5601	info@brioprimarycare.com
Phone Number	*Fax Number*	*Email Address*

Types of Medical Records to be Released

☐ Entire Record ☐ Immunization Record ☐ Progress / Visit Notes

Substance Use Disorder (SUD) Records Protected Under 42 C.F.R. Part 2 and 45 C.F.R. pts 160 & 164

☐ All of My SUD Records ☐ Only the Following (be as specific as possible) _____

Purpose of Release

☐ Transfer of Care ☐ Referral / Continuing Care

Information That Can Be Released

☐ Treatment Dates from _____ to _____ ☐ All Treatment Dates

By my signature I authorize release of the medical records specified above and agree that I have been offered a copy of this document as it is available in the office of Brio Primary Care with MUSC Health as well as online at www.brioprimarycare.com. This authorization is valid from the date of this document and will expire 180 days after that date. I acknowledge that the office releasing information may terminate my patient status upon transfer of records to Brio Primary Care.

I authorize the release of the records as indicated above and understand that the release may include sensitive information (mental and behavioral health, genetic testing, HIV/AIDS, communicable/infectious diseases, substance use disorder(s), and sexual assault).

Rights of the Patient: I understand that I have the right to revoke this authorization at any time by sending notification to Brio Primary Care, 2 Bella Grove Drive, Greenville, SC 29607. I understand that revocation is not effective in cases where the information has already been used or disclosed, but will be effective going forward. I understand that my treatment, payment, enrollment, or eligibility is not dependent on whether or not I sign this authorization. I understand that information used or disclosed as a result of this authorization may result in re-disclosure by the recipient and may no longer be protected by federal or state law. Information received by this office is for our own use and will continue to be protected by our Privacy Policy. I understand that I have the right to inspect or copy the protected health information disclosed as described in this document. I can do this by written notification to Brio Primary Care, 2 Bella Grove Drive, Greenville, SC 29607. I understand that I have the right to refuse to sign this authorization.

_____ _____

Patient / Guardian of Patient Signature Date Completed

PRIMARY CARE
with MUSC Health

First Name _____ Last Name _____ Date of Birth _____

Telehealth Consent Form

Purpose: The purpose of this form is to obtain your consent to participate in Telehealth at Brio Primary Care.

Nature of Telehealth at Brio Primary Care:

- Details of your medical history, current symptoms, examinations, X-Rays, test results, etc will be discussed through interactive video, audio, and telecommunication technology.
- You may be asked to come into the office for a physical exam if your Provider feels necessary for follow up care.
- Video, audio and/or photo recordings may be taken of you during the procedure or service.

Medical Information and Records: All existing laws regarding your access to medical information and copies of your medical records still apply to Telehealth at Brio Primary Care. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information to researchers or other entities shall not occur without your consent.

Confidentiality: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the provision of Telehealth at Brio Primary Care, and all existing confidentiality protections under federal and South Carolina state law apply to information disclosed during Telehealth at Brio Primary Care.

Rights: You may withhold or withdraw consent to Telehealth at Brio Primary Care at any time without affecting your right to future care or treatment, or risking the loss of withdrawal of any program benefits to which you would have otherwise been entitled.

Disputes: You agree that any dispute arriving from Telehealth at Brio Primary Care will be resolved in South Carolina and that South Carolina law shall apply to all disputes.

Risks, Consequences, and Benefits: You have been advised of all of the potential risks, consequences, and benefits of Telehealth at Brio Primary Care. Your health care Provider has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and Telehealth at Brio Primary Care. All your questions have been answered and you understand the written information provided above.

Consent:

☐ I agree to participate in Telehealth at Brio Primary Care

☐ I refuse Telehealth at Brio Primary Care

_____ _____

Patient Signature Date Completed

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First Name	Last Name	Date of Birth

Controlled Medication Agreement

1. Controlled medication prescriptions will be given during an office visit or Televisit in an adequate amount to cover you until your next appointment. It is important to schedule your next appointment before you leave the office or via a call back from a Brio team member following your Televisit.

2. Some controlled medication prescriptions cannot be mailed, faxed, or called into the pharmacy.

3. Any request for changes in prescribed medication will require a follow-up visit to determine the appropriateness of medication changes and to issue any new prescriptions.

4. Brio Primary Care is to be promptly notified in the event that the medication prescriptions or prescribed medication is lost, stolen, or rendered unusable. Such an occurrence will be thoroughly evaluated by the Provider prior to the issuance of a replacement prescription.

5. You are advised to promptly contact Brio Primary Care if you become or plan to become pregnant.

6. Any suspected inappropriate use / abuse of prescribed medication is to be promptly reported to Brio Primary Care. Providers will periodically run a SCRIPTS report (Prescription Drug Monitoring Database) to track prescription history of patients and may perform a random urine drug screen test.

I have read and understand the above controlled substance treatment guidelines. I understand that failure to follow the above guidelines may result in discontinuation of further treatment by Brio Primary Care.

Patient Signature	Date Completed