Dr. Sue Mitra, MD
397 N. Wickham Road, Suite 101
Melbourne, FL 32935
Phone: (321) 622-6222 | Fax: (321) 622-6660

WELCOME TO OUR PRACTICE!

Sue Mitra MD, FACP

Board Certified
Internal Medicine

Dr. Mitra has been practicing in Brevard County since 2002. Dr. Mitra received her medical degree from the University of Calcutta, India. She received a special merit scholarship and obtained a gold medal for securing the top rank in her class throughout her medical school curriculum. Dr. Mitra subsequently preformed a year of clinical research in Cardiovascular Medicine at the University of Florida College of Medicine, Gainesville, FL and published articles in journals. She then completed three years of residency training from the University of Florida in Gainesville. Dr. Mitra is a member of the American College of physicians and the American Society of internal Medicine. Her goal is to treat all patients with dignity, professionalism, compassion and care. Dr. Mitra has served as the President of Brevard Indo-American Medical and Dental Association in 2009.

Dr. Mitra has hospital privileges at Holmes Regional Medical Center, Viera Hospital, and Melbourne Regional Medical Center, Melbourne.

Dr. Mitra has special interest in heart disease, hypertension, diabetes and metabolic screening, cancer screening, routine job physical exams, mental health screening and counselling, tobacco cessation, weight management, osteoporosis screening, preventive medicine and health maintenance.

In her spare time, **Dr. Mitra** enjoys traveling, reading journals and magazines, painting, arts and crafts, music & computers.

Dear _____

Welcome To Our Practice

Your Consultation with Dr. Sue Mitra Is Scheduled for:

_____

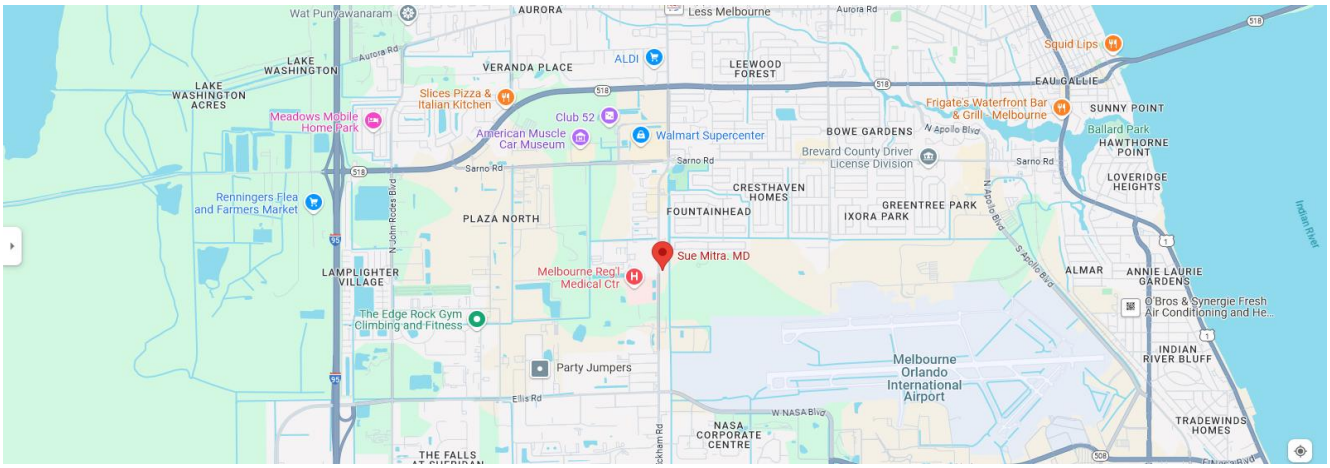
Be sure to fill everything in this attached packed to your best knowledge so that we may assist you accurately and thoroughly.

Please make sure your insurance reflects Dr. Mitra as your Primary Care Physician prior to your new patient appointment.

Please return your health information to our office before your visit so there is no delay at your arrival.

If you need to cancel or reschedule your appointment, please contact the office 24 hours prior to avoid a **$25** missed appointment fee. A no show fee of **$25** will be charged otherwise.

Thank you and we look forward to meeting you!



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PATIENT INFORMATION

PATIENT INFORMATION _____ / _____ / _____ / _____ ☐ MALE ☐ FEMALE
(LAST) (FIRST) (MI) (NICKNAME)

DOB ___/___/___ SOCIAL SECURITY # ___-___-___ MARITAL STATUS: ☐ Single ☐ Married ☐ Other

ADDRESS _____ / _____ / _____
(STREET) (CITY, STATE) (ZIPCODE)

HOME PHONE (___) ___-___ CELL PHONE (___) ___-___ WORK PHONE (___) ___-___

EMAIL ADDRESS _____ @ _____

PHARMACY NAME _____ LOCATION _____

EMPLOYER _____ OCCUPATION _____

NAME OF SPOUSE OR PARENT _____

ADDRESS _____ / _____ / _____
(STREET) (CITY, STATE) (ZIPCODE)

EMERGENCY CONTACT INFORMATION

NAME _____ RELATIONSHIP _____ PHONE # (___) ___-___

REFERRING PHYSICIAN _____ FAMILY DOCTOR _____ PHONE # (___) ___-___

INSURANCE INFORMATION - PRIMARY

INSURANCE CO. _____ POLICY # _____

POLICY HOLDER NAME _____ DOB ___/___/___ S.S. # ___-___-___

INSURANCE INFORMATION - SECONDARY

INSURANCE CO. _____ POLICY # _____

POLICY HOLDER NAME _____ DOB ___/___/___ S.S. # ___-___-___

I understand that I am financially responsible for all charges for services to me, including co-payments, co-insurance, out-of pocket deductibles and non covered services. I authorize the payments from my insurance company(s) according to my medical benefits be made payable to Medical Associates of Brevard for professional services rendered. I understand that I will receive statements, reflecting my account balance and that the FINAL PAYMENT of this account is my responsibility. Furthermore should I default on payment for services rendered I agree to pay all collection costs including reasonable attorney's fee. I authorize the disclosure of my medical information to all of Medical Associates of Brevard as well as to my insurance company(s).
LIFETIME SIGNATURE AUTHORIZATION: This signature and assignment is to be a continuing one, remaining in effect until revoked in writing by the undersigned. It signifies that all information given is current.

SIGNED _____ Date ___/___/___

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Patient Information

Patient Name

First_____MI_____Last_____

Date:____/____/_____ SS# _____

Marital Status _____ ☐ Male ☐ Female

Address _____

_____

Home Phone (___) ____-_____ Cell(___) ____-_____

Work Phone (___) ____-_____

Employer_____

Occupation_____

Name of Spouse_____

Employer_____

Address _____

_____

◯ Check if same as patient's address

Race

◯ American Indian or Alaska Native ◯ Asian
◯ Native Hawaiian ◯ Black or African American ◯ White
◯ Other Pacific Islander ◯ Prefer not to answer

Ethnicity

◯ Hispanic/Latino ◯ Non-Hispanic/Latino
◯ Prefer not to answer

Preferred Language

◯ English ◯ Spanish ◯ French ◯ Indian
◯ Other _____

Preferred Pharmacy _____

Location _____

Family Doctor _____

Phone (___) ____-_____

Insurance Information

Primary Insurance Co_____
Policy holder information, if not same as patient

Name_____

DOB:____/____/_____ SS# _____

Secondary Insurance Co_____

Policy #:_____
Policy holder information, if not same as patient

Name_____

DOB:____/____/_____ SS# _____

Complete below if patient is a minor

Father's Name (or Guardian) _____

DOB: ____/____/_____ SS# _____

Home Phone (___) ____-_____ Cell (___) ____-_____

Work Phone (___) ____-_____

Address _____

_____

◯ Check if same as patient's address

Employer _____

Mother's Name (or Guardian)_____

DOB:____/____/_____ SS# _____

Home Phone (___) ____-_____ Cell(___) ____-_____

Work Phone (___) ____-_____

Address _____

_____

◯ Check if same as patient's address

Employer _____

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New Patient Registration – HIPPA Release

Patient Name

First_____MI_____Last_____

Emergency Contact:

Name_____ Relationship_____

Phone# (____) _____-_____

I authorize Medical Associates of Brevard LLC to discuss my healthcare information wih the below:

Name_____ Relationship_____

Phone# (____) _____-_____

Name_____ Relationship_____

Phone# (____) _____-_____

Preferred appointment reminder notification:
◯Home Phone ◯Cell ◯Cell Text ◯Work Phone
◯Mail ◯E-Mail ◯None
◯With the person(s) authorized above

Preferred medical information notification:
I authorize medical associates of Brevard LLC to leave a detailed message which may contain personal health information via:
◯Home Phone ◯Cell ◯Cell Text ◯Work Phone
◯Mail ◯E-Mail ◯None
◯With the person(s) authorized above

Do you have a Living Will?:
◯Yes ◯ No

Do you have an Advance Directive?:
◯Yes ◯ No
If you answered Yes to either, please provide us a copy.

Note that authorization to contact via phone includes authorization for us to leave a message on your voicemail or answering machine

Your HIPPA contact information will be recorded as you have indicated here. You will be asked to electronically sign to confirm this information.

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HIPAA RELEASE

I authorize Medical Associates of Brevard to discuss my health care information with:

Name:_____ (Relationship):_____ Phone Number (_____) _____-_____

Name:_____ (Relationship):_____ Phone Number (_____) _____-_____

Signed:_____ Date:_____/_____/_____

I authorize Medical Associates of Brevard to leave a detailed message on my answering machine.

Signed:_____ Date:_____/_____/_____

Notice of Privacy Practices

I acknowledge that I have received a copy of the Provider Notice of Privacy Practices for Medical Associates of Brevard. The provider notice of privacy practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Provider Notice of Privacy Practices also describes my right and the responsibilities of duties of Medical Associates of Brevard with respect to my protected health information.

Print name of patient or personal representative

_____

Signature of Patient or Personal Representative

_____ Date:_____/_____/_____

Signature of Witness

_____ Date:_____/_____/_____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____ Date of Birth:_____/_____/_____

Phone Number (_____) _____-_____ Social Security:_____

I request and authorize the release of my healthcare information to the correct physician(s) And/or facility(s) stated below. This request and authorization applies to:

- Any/ All Healthcare Information

- Specific: _____

Medical Records Released From:
Dr.
Phone:
Fax:

Release Medical Records To:
Dr. Sue Mitra
397 N, Wickham Road Suite 101
Melbourne, FL 32935
Phone: **321-622-6222**
Fax: **321-622-6660**

Patient Signature:_____ Date Signed:_____/_____/_____

Witness / Guardian:_____ Date Signed:_____/_____/_____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER SIGNED

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION.

PLEASE REVIEW IT CAREFULLY

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on September 1, 2013 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased we may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. The Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. A fee will be charged to cover coping costs and the staff time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)

We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Research: We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Your Health Information Rights

Inspect and Copy: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Coping fees as allowed by Florida Statues will apply. If you prefer a summary or an explanation of your health information, we will provide it for a fee. If you want the copies mailed to you, postage will also be charged. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Access to your health information in electronic form, if readily producible, may be obtained with your request. A fee will be charged to cover the cost of staff to produce the electronic copy and the cost of the electronic media unto which the copy is saved. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. Please contact our Privacy Officer for an explanation of our fee structure.

Request Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). **"Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."**

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US:

Sue Mitra, MD
Internal Medicine

Office Contact: Sandra Hagloch
397 N, Wickham Road, Suite 101
Melbourne, FL. 32935

Tel: (321) 622-6222
Fax: (321) 622-6660

MAB Privacy Officer: Christopher Kelly
Tel: (321) 253-2900
Fax: (321) 435-0100

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HEALTH HISTORY QUESTIONNAIRE

Name:_____ DOB:_____/_____/_____ Sex:_____

Marrital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

FAMILY HISTORY

FAMILY	AGE	ILLNESSES	CAUSE OF DEATH IF DECEASED	AGE DECEASED
Mother				
Father				
Siblings How Many?_____				
Children How Many?_____				

CURRENT MEDICATIONS

Drug Name/Strength	Dosage Amount

DRUG ALLERGIES

Drug Name	Reaction

OPERATIONS/HOSPITALIZATIONS

Surgery/Hospitalizations	Approximate Date/Year

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PERSONAL HISTORY AND HEALTH HABITS

Current Complaint/Illness:_____

_____

Year of Elementary		**Have you ever used tobacoo products?**	**Yes_____ No_____**
Years if High School		**Age Started_____ Age Quit_____**	**Pack Per Day_____**
Years of College		**Do you drink alcohol? Yes_____ No_____**	**How Much?_____**
Place of Birth		**Do you use recreational Drugs? Yes____ No____**	**What Type?_____**
Occupation		**Do you have any pets in your home? Yes___ No___**	**What Type?_____**
Hazard Exposures			

PLACE AN (X) ON THE FOLLOWING TESTS YOU HAVE HAD & DATE WHEN LAST DONE:

Chest X-Ray	Date:	**Mammogram**	Date:
Low Dose CT Chest	Date:	**Pap Smear**	Date:
Electrocardiogram	Date:	**RSV Vaccine**	Date:
Colonoscopy	Date:	**Flu Vaccine**	Date:
Cholesterol Panel	Date:	**Covid Vaccine**	Date:
Bone (Dexa) Scan	Date:	**Tetanus Vaccine**	Date:
Dermatology Exam	Date:	**Shingles Vaccine**	Date:
Eye Exam	Date:	**Pneumonia Vaccine**	Date:

PLACE AN (X) IF YOU HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

Allergy/Hay Fever		**Diabetes**		**Depression**	
Asthma/COPD		**Heart Disease**		**Anxiety/Panic Attacks**	
Acid Reflux/GERD		**High Blood Pressure**		**Scoliosis**	
Cancer		**High Cholesterol**		**Other:**	
Chronic Kidney Disease		**Stroke/Seizure**		**Other:**	

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REVIEW OF SYMPTOMS

Place an(x) after the signs or symptoms which you frequently have had or presently have:

GENERAL		MUSCULOSKELETAL		DIGESTIVE		URINARY TRACT		LUNGS
Fever		Joint Pain		Difficulty Swallowing		Frequent Urination		Wheezing
Night Sweats		Joint Swelling		Pain When swallowing		Frequently getting up at night to Urinate		Dry Cough
Fatigue		Muscle Aches		Heartburn		Painful Urination		Cough with Phlegm
Weight Loss		Shoulder Pains		Stomach Pain		Blood In Urine		Shortness of Breath during Activity
Weight Gain		Back Pain		Diarrhea		Difficulty Urinating		Blood in Sputum
Loss of Appetite		Morning Stiffness		Vomiting		Kidney Disease		Painful Breaths
Chills		Painful/Swollen Toes		Black Stool		Kidney Stones		**SLEEP ISSUES**
NEUROLOGICAL		**HEART**		Constipation		Male Genital		Difficulty Falling Asleep
Light-headedness		High Blood Pressure		**SKIN**		Weak Stream		Sleep Disturbance
Fainting Spells		Chest Pain		Itching of Skin		Discharge from Penis		Daytime Fatigue/Sleepiness
Convulsions		Palpitation		Easy Bruising		Sores on Penis		Snoring
Tremors		Heart Murmur		Rash		History of Venereal Disease		**ANKLE/FOOD**
Sudden Periodic Loss of Vision		Swelling of Ankles/Feet		Ulceration		Difficulty Obtaining Erection		Foot/Ankle Injury
Sudden Fall to the Floor		Leg Cramps		Discoloration		Painful Testicles		Foot/Ankle Pain
Loss of Consciousness		**EYES**		**HEAD**		Testicle Swelling/Lumps		Foot/Toe Deformity
Memory Loss		Worsened Eyesight		Frequent Headaches		Prostate Trouble		Bunions/Hammer Toes
SINUSES		Blurred Vision		Painful or Tender		**FEMALE GENITAL**		**BREASTS** (Male & Female)
Frequent Congestion		Sudden Blindness		Acute Sinus Issues		Vaginal Discharge		Breasts Soreness
Frequent Nose Bleeds		Double Vision		**MOUTH**		Vaginal Itching		Discharge From Breast
Sinus Pain		**NECK**		Tooth Ache		Menstruation Issues		Recent Enlargement
Sinus Drainage		Neck Pain		Easy Bleeding of Gums		Excessive Bleeding		Breast Lump
Nasal Polyps		Neck Stiffness		Tooth Decay/Loss		Light Bleeding/Spotting		
Hoarseness		Swelling in Neck/Underarms		Frequent Thrush		History of Venereal Disease		