PCCC/RDC/NDC/EDC of Volusia

P: 386-423-0505 F: 386-423-0515

Last Name:____________________ First Name:____________________ Preferred:____________

DOB: _______________ SS#:________________________________ Sex: ☐ Male ☐ Female

Race: ☐ Caucasian ☐ African American ☐ Hispanic/Latino ☐ Native American ☐ __________

Address:____

Phone Number: (Home)_________________ (Work)_______________ (Cell)_________________

Primary Care Physician:_________________________ Referring Provider:___________________

Email:____________________________________ Request Patient Portal Access? ☐ Yes ☐ No

Emergency Contact: _______________________________ **Phone:** _________________________

Insurance Information

Primary Insurance

Insurance Company: ____

Policy/ID Number: _____________________________ Group: ____________________________

PLEASE SUPPLY THE FOLLOWING ONLY IF THE PATIENT IS NOT THE PRIMARY POLICY HOLDER:

Primary Policy Holder:_____________________________ Date of Birth:____________________

Address:____

Secondary Insurance

Insurance Company: ____

Policy/ID Number: _____________________________ Group: ____________________________

PLEASE SUPPLY THE FOLLOWING ONLY IF THE PATIENT IS NOT THE PRIMARY POLICY HOLDER:

Primary Policy Holder:_____________________________ Date of Birth:____________________

Address:____

BENEFIT ASSIGNMENT/RELASE OF INFORMATION

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Private Insurance, or any other health/auto insurance plans to PCCC/RDC/NDC/EDC of Volusia. A photocopy of this assignment is to be considered to be as valid as the original. I hereby authorize said assignee to release all information necessary (including photocopies of medical records) to secure payment (see notice of privacy practices). Also, by signing below, I am attesting that I have received a copy of the privacy practices for this office (available from receptionist).

Signature of Patient ________________________________ Date _________________________

It is the patient's responsibility to be aware of all individual plans, policies, and benefits. The filing claims for you does not guarantee payment from your insurance company, nor should it be considered a binding agreement of payments and/or benefits from your insurance company. As a patient of PCCC/RDC/NDC/EDC of Volusia you are responsible for the entire bill of services should your insurance company deny payment for any reason. By signing this statement as guarantor, you agree to pay for all services and/or supplies that are deemed patient responsibility by either PCCC/RDC/NDC/EDC of Volusia or your insurance company.

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Dr. Rajesh Ailani Dr. Theodosis Zacharis Dr. Christopher DiBello
Dr. Maria Vintimilla Dr. Vicente Trapani Dr. Christina Rho
Heaven Turner, APRN Erika Morrison, APRN Ashley Pascucci APRN
Tamara Schilsky, APRN Ashley Cortes, APRN Matthew Rossi, APRN
Amanda Seegobin, APRN Delaney Rodriguez, APRN

Personal Healthcare Confidant

I, ____________________________, elect the following person/people, listed below as my Personal Healthcare Confidant (s***). I give permission to the above named physicians and their office staff to release any and all information regarding my medical treatment to my elected Personal Healthcare Confidant (s)***. I understand that should I choose to change or remove an elected person, I must do so in writing in the presence of the staff or by sending my notarized request in the mail.

Elected Person	**Relationship**

May we leave messages on your answering machine or voicemail regarding your health (including but not limited to: Lab, Radiology Reports, Appointments)

__ Yes __ No

Patient Signature______________________________________ Date ________________________________

*Notary____ Date ________________________________

***Only need notary if patient is not signing in front of a member of the office staff**

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Name ______________________________________ DOB ________________________________

PAST MEDICAL HISTORY

__ Diabetes
__ High Blood Pressure
__ Coronary Artery Disease
__ Lung disease (_________)
__ Kidney Disease
__ Liver Disease
__ Thyroid Disease
__ Vascular Disease
__ Bleeding Problems
__ Heart Attack
__ Angina
__ Stroke
__Seizures
__ Ulcers
__ Asthma
__ Heart Murmur
__ Emphysema
__ Back Injury
__ Rheumatic Fever
__ Cancer (Type) __________________________
__ Other Medical Problems ____

ALLERGIES:

____

SOCIAL HISTORY:

__ Cigarettes ___ Years ___ Packs Per Day Occupation ______________________

__ Quit Smoking: ____________________ __ Alcohol (Type and Amount) __________________

SURGICAL HISTORY:

PROCEDURE	DATE

FAMILY HISTORY: (***Please specify family member)***

__Heart Disease ____________________
__ High Blood Pressure________________________
__ Diabetes ________________________
__Cancer__________________________________
__ Stroke _________________________
__ Lung Disease______________________________
__ Kidney Disease _________________

CHILDREN: How Many? ________________________ Ages? __________________________

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Name ______________________________ DOB _______________ Todays Date _______________

Pharmacy of Choice ____

Location ____

Phone ______________________________ Fax ____

Preferred Lab _________________________ Preferred DME Company ________________________

MEDICATION	**STRENGTH**	**FREQUENCY**

PLEASE BE SURE TO LIST VITAMINS AND SUPPLLEMENTS AS WELL

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GENERAL OFFICE POLICIES

MISSED APPOINTMENTS

If you need to cancel your appointment we require 24 hour notice so we may be able to offer your appointment to someone else. You may call any office to cancel your appointment. Missed appointments may be billed for $25 and are not covered by your insurance.

RETURNED CHECK FEES

There will be a $20 fee on all returned checks, in addition to any bank fees assessed.

FORMS FEES

There will be a charge for forms to be filled out by the doctors ranging from $25-$50.

WALK INS

We ask that when you are sick please call the office you wish to be seen at and we will do our best to get you in to see a physician. We might recommend that you see your primary care physician or possibly go to the emergency room instead.

PRESCRIPTION REFILL POLICY

Please call your pharmacy directly for any prescription refills even if the prescription has expired. The pharmacy will contact us directly for refills. (This applies to all insurances except Florida Health Care)

Prescriptions not written by Dr. Rajesh Ailani, Dr. Theodosis Zacharis, Dr. Christopher DiBello, Dr. Maria Vintimilla, Dr. Vicente Trapani, Dr. Christina Rho, Heaven Turner ARNP, Erika Morrison ARNP, Ashley Pascucci ARNP, Ashley Cortez ARNP, Tamara Schilsky ARNP, Matthey Rossi ARNP, Delaney Rodriguez ARNP, or Amanda Seegobin ARNP will not be filled. These will need to be filled by the prescribing doctor.

Please allow two business days for refill requests and at least 1 week for all controlled substance medication refills.

Prescriptions will only be filled during business hours. No prescriptions will be filled after 12pm on Friday or on the weekends.

****By signing the document below I agree to the above terms and conditions of this office and understand that non-compliance of the terms may result in termination from the practice.**

PRINTED NAME____
SIGNATURE OF PATIENT____________________________________DATE_________________

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Patient Name: ____

Address: ____

City: ____________________________ State: ________ Zip Code: ____________

Phone Number: ______________________ DOB: ______________________

Medical Records Request

I hereby authorize *PCCC/RDC/NDC/EDC of Volusia* to request patient information from:

Name/Facility: ____

Address: ______________________City: ______________State: _______Zip: __________

Phone: ______________________ Fax: ______________________

Information to be released:

- Clinic Notes
- History & Physical
- Medication List
- Lab Reports
- Radiology Reports
- Last 3 Years
- All Records
- Other:____________ __________________

Medical Records Release

I hereby authorize *PCCC/RDC/NDC/EDC of Volusia* to release patient information to:

Name/Facility: ____

Address: ______________________City: ______________State: _______Zip: __________

Phone: ______________________ Fax: ______________________

Information to be released:

- Clinic Notes
- History & Physical
- Medication List
- Lab Reports
- Radiology Reports
- Last 3 Years
- All Records
- Other:____________ __________________

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that specific information to be released may include, but is not limited to, history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS. I understand that I may withdraw this consent at any time.

Patient Signature: __________________________ Date: ____________________

NOTICE: If you have received this communication in error, please notify us and return the original message. This information is confidential and intended only for the use of the above named. If the reader of this message is not the intended recipient, you are hereby notified that the use or copying of the information is strictly prohibited. Thank you. Expires 3 years from date listed above.