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Bellevue, Florida 34420
Tel: 352-347-5225
Fax: 352-347-1073

2500 Citrus Blvd.
Leesburg, Florida 34748
Tel: 352-728-5335
Fax: 352-347-1073

Acct. # _____

Entered by _____

Thank you for selecting our healthcare team! We will strive to provide you with the best possible health care. To help meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

PERSONAL INFORMATION

Date _____

Birthdate _____ Soc. Sec. # _____

Name _____

Wishes to be called _____

() Male () Female () Minor () Single () Married () Divorced () Widowed () Separated

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext. # _____

Employer _____ Occupation _____

Referred by _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Ext. # _____

RESPONSIBLE PARTY

Who is responsible for the account?

Name _____

Relationship to patient _____

Birthdate _____ Driver License # _____ Soc. Sec. # _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext. # _____

INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: _____

Insured's Birthdate: _____ Soc. Sec. #: _____ Group #: _____

Employer: _____ Insurance Co.: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE FOLLOWING

Name of Insured: _____ Relationship to Patient: _____

Insured's Birthdate: _____ Soc. Sec. #: _____ Group #: _____

Employer: _____ Insurance Co.: _____

AUTHORIZATION AND RELEASE

I authorize Express Care of Belleview to release to any third party payor any information including the diagnosis and the records of any treatment or examination rendered to me or my child for its use in connection with determining a claim for payment or when required by a third party provider in the assessment, planning, and/or implementation of my care.

If a Medicare/Medicaid beneficiary, I certify that the information given by me in applying payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services any information needed for this or a related Medicare/Medicaid claim.

I authorize and request all insurance payments pertaining to treatment shall be assigned to the physician, physician assistant or nurse practitioner treating me. I understand that my insurance carrier may pay less than the actual fees for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that all fees still pending with insurance carriers after 90 days will be my responsibility.

FINANCIAL POLICY

PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED – We offer the following methods of payment for services not covered by your insurance. Please check the method you prefer.

_____ Cash _____ Check (Returned checks are subject to a \$30.00 fee.)

_____ Credit Card. Credit Card #: _____ Exp. Date: _____

MasterCard Visa Discover American Express Name on Credit Card: _____

This credit card will be billed for any outstanding balances. X _____

We must emphasize that as your medical care provider, our relationship and concern is with you and your health, not your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY FOR THE DATE SERVICES ARE RENDERED.** We realize that emergencies do arise and may affect timely payment of your account. You may receive an additional bill for lab work done or for services rendered that were not charged on the date of service.

CONSENT FOR TREATMENT: I consent freely and voluntarily to participate in the treatments that may be ordered by my Health Care Provider. I understand that I may withdraw consent at any time.

PATIENT (GUARANTOR) SIGNATURE: _____ DATE: _____

HEALTH HISTORY

PATIENT NAME _____ BIRTHDATE ____ / ____ / ____ PATIENT # _____

To help us meet all your healthcare needs, please fill out **both sides** of this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Today's date _____
 Place of birth _____
 Highest level in school _____
 Occupation _____
 Hobbies _____
 Exercise/recreation _____

Habits:
 Smoking (type & amount per day) _____
 If former smoker, date quit _____
 Alcohol (type & amount per week) _____
 Caffeine (type & amount per day) _____
 Street drugs (type & amount per day) _____

Usual weight _____
 Date of last dental exam _____
 Please list all allergies (foods, drugs, environment)

When was your last physical exam? _____
 Name of doctor _____ Phone _____
 Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred: none

Please list all medicines you are currently taking (include nonprescription drugs): none

Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred): none

Chief Complaints:

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles _____ no yes	Migraine headaches no yes	Hives or Eczema ___ no yes
Mumps _____ no yes	Tuberculosis _____ no yes	AIDS or HIV + _____ no yes
Chickenpox _____ no yes	Diabetes _____ no yes	Infectious Mono _____ no yes
Whooping Cough ___ no yes	Cancer _____ no yes	Bronchitis _____ no yes
Scarlet Fever _____ no yes	Polio _____ no yes	Mitral Valve Prolapse ___ no yes
Diphtheria _____ no yes	Glaucoma _____ no yes	Stroke _____ no yes
Smallpox _____ no yes	Hernia _____ no yes	Hepatitis _____ no yes
Pneumonia _____ no yes	Blood or Plasma ___ no yes	Ulcer _____ no yes
Pneumatic Fever ___ no yes	transfusions	Kidney Disease _____ no yes
Heart Disease _____ no yes	Back trouble _____ no yes	Thyroid Disease _____ no yes
Arthritis _____ no yes	High or low blood ___ no yes	Bleeding tendency _ no yes
Venereal Disease ___ no yes	pressure	Any other disease ___ no yes
Anemia _____ no yes	Hemorrhoids _____ no yes	(please list) _____
Bladder Infections _ no yes	Date of last chest x-ray _____	_____
Epilepsy _____ no yes	Asthma _____ no yes	_____

Family History

Has any blood relative had any of the following: (Circle "no" or "yes", leave blank if uncertain)

Cancer _____ no yes	Stroke _____ no yes
Tuberculosis _____ no yes	Epilepsy _____ no yes
Diabetes _____ no yes	Allergies _____ no yes
Heart Disease _____ no yes	Anemia _____ no yes
High blood pressure no yes	Bleeding tendency _ no yes

Family History (cont.)

(Circle "no" or "yes", leave blank if uncertain)

Present age,
or age of death

If living, health (good, fair, poor)
If deceased, cause of death

		Relationship	Father _____
Asthma _____	no yes	_____	Mother _____
Chronic lung disease _____	no yes	_____	Siblings _____
Drug or Alcohol problem _____	no yes	_____	_____
Mental Illness _____	no yes	_____	_____
Leukemia _____	no yes	_____	_____
Migraine headaches _____	no yes	_____	_____
Obesity _____	no yes	_____	Spouse _____
Thyroid Disease _____	no yes	_____	Children _____
Ulcer _____	no yes	_____	_____
Depression _____	no yes	_____	_____
High Cholesterol _____	no yes	_____	_____
Kidney Disease _____	no yes	_____	_____
Glaucoma _____	no yes	_____	_____
Gout _____	no yes	_____	_____

Do you have now or have you had within the past year:

(Circle "no" or "yes", leave blank if uncertain)

Weakness or paralysis _____	no yes	Wheezing _____	no yes	Joint pain or stiffness _____	no yes
Tire easily or weakness _____	no yes	Chest pain or discomfort _____	no yes	Swollen joints _____	no yes
Recent weight changes _____	no yes	Purple fingers or lips _____	no yes	Muscle cramps or spasms _____	no yes
Change in appetite _____	no yes	Swelling of hands, feet or ankles _____	no yes	Sleeplessness _____	no yes
Sensitivity to cold or heat _____	no yes	Difficulty in breathing _____	no yes	Seizures _____	no yes
Persistent fever _____	no yes	Palpitations or fluttering of the heart _____	no yes	Depression _____	no yes
Night sweats or hot flashes _____	no yes	Leg cramps on walking or at night _____	no yes	Memory loss _____	no yes
Skin rash _____	no yes	Enlarged veins _____	no yes	Poor coordination _____	no yes
Skin trouble or changes _____	no yes	Difficulty swallowing _____	no yes	Dizziness or fainting spells _____	no yes
Change in nails or hair _____	no yes	Heartburn _____	no yes	Do you have a Living Will? _____	no yes
Headaches _____	no yes	Frequent belching _____	no yes	If "no", do you want information? _____	no yes
Easy bleeding or bruising _____	no yes	Abdominal cramping _____	no yes	If "yes", please supply a copy	
Double vision _____	no yes	Nausea _____	no yes	Men only:	
Blurred vision _____	no yes	Vomiting _____	no yes	Discharge from penis _____	no yes
Eye pain _____	no yes	Vomited or coughed up blood _____	no yes	Pain or lump in testicles _____	no yes
Infected eyes _____	no yes	Chronic diarrhea _____	no yes	Impotence _____	no yes
Do you wear glasses or contacts _____	no yes	Chronic constipation _____	no yes	Women only:	
When was your last eye exam _____		Rectal bleeding _____	no yes	Age period began _____	
Ringing in the ears _____	no yes	Black tarry stools _____	no yes	How many days do periods last? _____	
Discharge from ears _____	no yes	Dark urine _____	no yes	How many days between periods? _____	
Ear pain _____	no yes	Yellow jaundice _____	no yes	Is the flow heavy? _____	no yes
Decrease in hearing _____	no yes	Frequent urination (day) _____	no yes	Do you bleed or spot _____	no yes
Frequent nosebleeds _____	no yes	Frequent urination (night) _____	no yes	between periods?	
Frequent colds _____	no yes	Increase in thirst _____	no yes	Do you have pain or cramps? _____	no yes
Sinus trouble _____	no yes	Painful urination _____	no yes	Date of last period? _____	
Loss of smell _____	no yes	Leakage of urine _____	no yes	Date of last pelvic exam? _____	
Persistent hoarseness _____	no yes	Difficulty in starting urine _____	no yes	Date of last mammogram? _____	
Sore throat _____	no yes	Blood in urine _____	no yes	Any itching in vaginal area? _____	no yes
Sore tongue or gums _____	no yes	Lack of sex drive _____	no yes	Pain with intercourse? _____	no yes
Lump or discharge from breast _____	no yes	Hemorrhoids _____	no yes	Type of birth control used? _____	
Chronic or frequent cough _____	no yes	Backaches _____	no yes	Number of pregnancies _____	
Shortness of breath _____	no yes			Number of full term births _____	
Bloody sputum _____	no yes			Number of preterm births _____	

X _____

Signature of patient or parent if minor

_____ Date

We will use your health information for regular health operations.

We may disclose your health information for our routine operations. These uses are necessary for certain administrative, financial, legal, and quality improvement activities that are necessary to run our practice and support the core functions.

For example:

Members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide and to reduce healthcare costs.

- Appointment Reminders

We may disclose medical information to provide appointment reminders (e.g., contacting you at the phone number you have provided to us and leaving a message as an appointment reminder).

- Decedents

Consistent with applicable law, we may disclose health information to a coroner, medical examiner, or funeral director.

- Workers Compensation

We may disclose health information to the extent authorized by and necessary to comply with laws relating to workers compensation or other similar programs established by law.

- Public Health

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

- Research

We may disclose information to researchers when their research has been approved and the researcher has obtained a required waiver from the Institute Review Board/Privacy Board, who has reviewed the research proposal.

- Organ Procurement Organization

Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of donation and transplant.

- As Required By Law

We may disclose health information as required by law. This may include reporting a crime, responding to a court order, grand jury subpoena, warrant, discovery request, or other legal process, or complying with health oversight activities, such as audits, investigations, and inspections, necessary to ensure compliance with government regulations and civil rights laws.

- Specialized Government Functions

We may disclose health information for military and veterans affairs or national security and intelligence activities.

- Business Associates

There are some services provided in our organization through contacts with business associates. Some examples are billing or transcription services we may use. Due to the nature of business associates' services, they must receive your health information in order to perform the jobs we've asked them to do. To protect your health information, however, when these services are contracted we require the business associates to appropriately safeguard your information.

- Practice Marketing

We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you (for example, to notify you of any new tests or services we may be offering).

- Food And Drug Administration (FDA)

We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

- Personal Representative

We may use or disclose information to your personal representative (person legally responsible for your care and authorized to act on your behalf in making decisions related to your health care).

- To Avert A Serious Threat To Health/Safety

We may disclose your information when we believe in good faith that this is necessary to prevent a serious threat to your safety or that of another person. This may include cases of abuse, neglect, or domestic violence.

- Communication With Family

Unless you object, health professionals, using their best judgment, may disclose to a family member or close personal friend health information relevant to that person's involvement in your case or payment to your care. We may notify these individuals of your location and general condition.

- Disaster Relief

Unless you object, we may disclose health information about you to an organization assisting in a disaster relief effort.

For all *non-routine* operations, we will obtain your written authorization before disclosing your personal information. In addition, we take great care to safeguard your information in every way that we can to minimize any incident disclosures.



NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

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.

Our Promise To You, Our Patients.

Your information is important and confidential. Our ethics and policies require that your information be held in strict confidence.

Introduction

We maintain protocols to ensure the security and confidentiality of your personal information. We have physical security in our building, passwords to protect databases, compliance audits, and virus/intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their jobs.

At the office of Express Care of Belleview/Leesburg, we are committed to reacting and using protected health information about you responsibly. This Notice of Privacy Policies describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by Federal regulations.

Understanding Your Health Record

Each time you visit Express Care of Belleview/Leesburg, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- Tool in educating health professionals,
- Source of data for medical research,
- Source of information for public health officials charged to improve the health of the state and nation,
- Source of data for our planning and marketing, and
- Tool by which we can assess and continually work to improve the care we render and outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy; better understand who, what, when, where, and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health care record is the physical property of Express Care of Belleview/Leesburg, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of privacy policies upon request,
- Inspect and obtain a copy of your health record as provided by 45 CFR 164.524 (reasonable copy fees apply in accordance with state law),
- Amend your health record as provided by 45 CFR 164.526,
- Obtain an accounting of disclosures of your health information as provided by 45 CFR 164.528,
- Request confidential communication of your health information as provided by 45 CFR 164.522(b), and
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522(a) (however, we are not required by law to agree to a requested restriction).

Our Responsibilities

Our practice is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate your health information.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our facility containing the effective date in the top, right-hand corner. In addition, each time you visit our facility for treatment, you may obtain a copy of the current notice in effect upon request.

We will use or disclose your health information in a manner other than described in the section regarding Examples Of Disclosures For Treatment, Payment, And Health Operations, without your written authorization, which you may revoke as provided by 45 CFR 164.508(b)(5), except to the extent that action has already been taken.

For More Information Or To Report A Problem

If you have questions and would like additional information, you may contact our practice's Privacy Officer:

Deanna Crimi, at (352) 347-5225

If you believe your privacy rights have been violated, you can either file a complaint with Deanna Crimi, or with the Office for Civil Rights, U.S. Department of Health and Human Service (OCR). There will be no retaliation for filing a complaint with either our practice or the OCR. The address for the OCR regional office for Florida is as follows:

Office for Civil Rights
U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth Street, S.W.,
Atlanta, GA 30303-8909

Examples Of Disclosures For Treatment, Payment, And Health Operations

We will use your health information for treatment.

We may provide medical information about you to health care providers, our practice personnel, or third parties who are involved in the provision, management, or coordination of your case.

For Example:

Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your medical information will be shared among health care professionals involved in your case.

We will also provide your other physician(s) or subsequent health care provider(s) (when applicable) with copies of various reports that should assist them in treating you.

We will use your health information for payment.

We may disclose your information so that we can collect or make payment for the health care services you receive.

For Example:

If you participate in a health insurance plan, we will disclose necessary information to that plan to obtain payment for your care.