

PCCC/RDC/NDC/EDC/NCCC 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/RELEASE 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 understand a copy of the privacy practices for this office is available to me on the MyHealthRecord portal or from a 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/NCCC 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/NCCC of Volusia or your insurance company.

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Dr. Rajesh Ailani
Dr. Theodosios Zacharis
Dr. Christopher DiBello
Dr. Maria Vintimilla
Dr. Vicente Trapani
Dr. Christina Rho

Dr. Jorge Castaneda
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 _____

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Dr. Christina Rho

Dr. Jorge Castaneda
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Erika Morrison, APRN
Ashley Pascucci APRN
Tamara Schilsky, APRN
Ashley Cortes, APRN

Matthew Rossi, APRN
Amanda
Seegobin, APRN
Delaney Rodriguez,
APRN

Name _____ DOB _____

PAST MEDICAL HISTORY

- | | | |
|-------------------------------------------------------|----------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Coronary Artery Disease |
| <input type="checkbox"/> Lung disease (_____) | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Angina | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Back Injury |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Cancer (Type) _____ | |
| <input type="checkbox"/> 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)

<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> High Blood Pressure _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Lung Disease _____
<input type="checkbox"/> Kidney Disease _____	

CHILDREN: How Many? _____ Ages? _____

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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. Theodosios Zacharis, Dr. Christopher DiBello, Dr. Maria Vintimilla, Dr. Vicente Trapani, Dr. Christina Rho, Dr. Jorge Castaneda, 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 _____