LAST NAME _____FIRST NAME _____NICKNAME _____
MIDDLE INITIAL

❒ MALE DATE OF BIRTH _____AGE_____SS# _____
❒ FEMALE

Race: Caucasian___ African American___ Hispanic/Latino___ Native American___ Other_____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____WORK PHONE _____CELL PHONE _____

## INSURANCE INFORMATION

***PRIMARY INSURANCE:***

INSURANCE CO._____
NAME CLAIMS ADDRESS CITY STATE ZIP

POLICY/ID NO. _____GROUP NO. _____

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

PRIMARY POLICY HOLDER _____ DATE OF BIRTH _____

ADDRESS _____
❒ SAME AS PATIENT CITY STATE ZIP

***SECONDARY INSURANCE:***

INSURANCE CO._____
NAME CLAIMS ADDRESS CITY STATE ZIP

POLICY/ID NO. _____ GROUP NO. _____

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

PRIMARY POLICY HOLDER _____ DATE OF BIRTH_____

ADDRESS _____
❒ SAME AS PATIENT CITY STATE ZIP

## BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INS., OR ANY OTHER HEALTH/AUTO INSURANCE PLANS TO *PCCC/RDC/NDC/EDC/BSMC OF VOLUSIA*. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED 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 (AVAILBLE FROM RECEPTIONIST).

SIGNATURE OF PATIENT _____ DATE _____

OR, GUARDIAN IF PATIENT UNDER THE AGE OF 18

NEXT PAGE →

IT IS THE PATIENT'S RESPONSIBILITY TO BE AWARE OF INDIVIDUAL PLANS, POLICIES AND BENEFITS. THE FILING OF CLAIMS FOR YOU DOES NOT GUARANTEE PAYMENT FROM YOUR INSURANCE COMPANY, NOR SHOULD IT BE CONSIDERED A BINDING AGREEMENT OF PAYMENT AND/OR BENEFITS FROM YOU INSURANCE COMPANY. AS A PATIENT OF PCCC/RDC/NDC/EDC/BSMC OF VOULSIA, YOU ARE RESPONSIBLE FOR THE ENTIRE BILL OF SERVICES SHOULD YOUR INSURANCE COMPANY DENY PAYMENT FOR ANY REASON. BY SIGING THIS STATEMENT AS A GUARANTOR, YOU AGREE TO PAY FOR ALL SERVICES AND/OR SUPPLIES THAT ARE DEEMED PATIENT RESPONSIBILITY BY EITHER PCCC OF VOLUSIA OR YOUR INSURANCE COMPANY.

**Rajesh K. Ailani, M.D.**
**Theodossis Zacharis, M.D.** **Christina Rho, M.D.**
**Christopher DiBello, M.D.** **Maria Vintimilla,M.D.**
**Vicente Trapani, M.D.** **Dina Doolin, D.O.**

## 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& all information regarding my medical treatment to my elected Personal Healthcare Confidant.*** 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 VOICE MAIL REGARDING YOUR HEALTH (*INCLUDING BUT NOT LIMITED TO: LABS, RADIOLOGY STUDIES, APPOINTMENTS*)

**☐YES ☐NO**

## PATIENT SIGNATURE _____

## DATE SIGNED _____

## ***NOTARY _____ DATE_____

***** ONLY NEED NOTARY IF PATIENT IS NOT SIGNING IN FRONT OF A MEMBER OF THE OFFICE STAFF*****

**NEXT PAGE →**

**Rajesh K. Ailani, M.D.**
**Theodossis Zacharis, M.D.** **Christina Rho, M.D.**
**Christopher DiBello, M.D.** **Maria Vintimilla,M.D.**
**Vicente Trapani, M.D.** **Dina Doolin, D.O.**

NAME _____ DOB _____ Todays Date_____

PHARMACY OF CHOICE _____

LOCATION _____

PHONE _____ Fax _____

| **MEDICATION** | **STRENGTH** | **FREQUENCY** |
|---|---|---|
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****PLESE BE SURE TO LIST VITAMANS AND SUPPLEMENTS AS WELL****

**NEXT PAGE** →

**Rajesh K. Ailani, M.D.**
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**Vicente Trapani, M.D.** **Dina Doolin, D.O.**

**Name:** **DOB:**

**PAST MEDICAL HISTORY**: _____Lung Disease ( _____ )
_____Coronary Artery Disease _____Diabetes _____High Blood Pressure
_____Kidney Disease _____Liver Disease _____Thyroid Disease
_____Vascular Disease _____Bleeding Problems _____Heart Attack
_____Angina _____Stroke _____Seizures
_____Ulcer _____Asthma _____Heart Murmur
_____Emphysema _____Back Injury _____Rheumatic Fever
_____Cancer (Type)_____
Any Other Medical Problems_____

**ALLERGIES:**

**SOCIAL HISTORY:** _____Cigarettes: _____Years _____Packs per day
_____Quit Smoking :_____
_____Alcohol (Type and Amount)_____
Occupation:_____

**SURGICAL HISTORY:**

| **Procedure** | **Date** |
|---|---|
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**FAMILY HISTORY:** *(Please specify family member)*
_____Heart Disease (_____) ___High Blood Pressure (_____)
_____Diabetes (_____) ____Cancer (_____)
_____Stroke (_____) ____Lung Disease (_____)
_____Kidney Disease (_____)

**CHILDREN: How many?** **Ages:**

# General Office Policies

## MISSED APPOINTMENTS

If you need to cancel your appointment, we require 24 hours notice so we may be able to offer your appointment to someone else. Please call our main number 423-0505, option 2. Missed appointments are billed at $20* and are not covered by insurance.

## RETURNED CHECK FEES

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

## WALK-INS

We ask that when you are sick, please call and speak with the nurse (423-0505, option 3) and we will do our best to get you in to see the physician. We might recommend that you see your primary care physician or possibly the Emergency Room instead.

## PRESCRIPTION REFILL POLICY

Please call your pharmacy directly for any prescription refills written by Dr. Rajesh Ailani, Dr. Theodossis Zacharias, Dr. Christina Rho, Dr. Chrisopher DiBello, Dr. Maria Vintimilla, Dr. Vicente Trapani, ARNP's Heaven Levine or Beth Patel *even if the prescription has expired*. The pharmacy will contact us for refills. (This applies to all insurances except Florida HealthCare Plans.)

Prescriptions *not written* by Dr. Rajesh Ailani, Dr. Theodossis Zacharias, Dr. Christina Rho, Dr. Chrisopher DiBello, Dr. Maria Vintimilla, Dr. Vicente Trapani, ARNP's Heaven Levine or Beth Patel will not be filled.

These will need to be filled by the prescribing doctor.

*Please allow two days for refill request.*

Prescriptions will only be filled during working hours.

No prescriptions will be filled after 12PM on Friday, or on the weekends.

***By signing the document below I acknowledge that I have read and understood the terms and conditions before mentioned. I further acknowledge that any non-compliance on my part could lead to the termination of the professional relationship between myself and our physicians, all medical staff of this practice.

Sign Name: _____ Date: _____

* Unless otherwise stated by your insurance company.

**PCCC of Volusia** /RDC/NDC/EDC/BSMC
1055 North Dixie Freeway, New Smyrna Beach, Fl. 32168
780 Dunlawton Avenue, Port Orange, Fl. 32127
575 Clyde Morris Boulevard, Suite B, Daytona Beach, Fl. 32114
638 West Plymouth Avenue, Deland, Fl. 32720

# Patient Financial Responsibility Disclosure Statement

Your signature below forms a binding agreement between any of the above mentioned providers (the provider of medical services) and the Patient who is receiving medical services or the Responsible Party for minor patients (those patients under 18 years old). A Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of service.

**Medical Insurance:** We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

- Inform front desk staff of the current address/phone number for the patient and the responsible party.
- Present all current insurance cars prior to each office visit.
- Verify at each visit that the Patient's information is current.
- Confirm that we take the Patient's insurance.
- Pay any required copay at the time of the visit.
- Pay any additional amount awing within 30 days of receiving a statement from our office.

**Returned Check Policy**

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient's Responsible Party will be responsible for the original check in addition to a $25.00 Service Charge, plus any additional back fees incurred by us. Once notice is received of the returned check, our office will call or send out a letter to notify the Responsible Party of the returned check. If the Patient or the Responsible Party does not respond within 15 days from the date on the letter, the account may be turned over to our collection agency and a collection fee of 50% will be added to the outstanding balance-in addition to the $25.00 Check Service Charge.

**Non-Payment on Account**

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that our providers have the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 18% APR, all court costs and Attorney fees, and a collection fee of 50% which will be added to the outstanding balance.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical service or as the responsible party for a minor patient under age 18 years old. Your signature verifies that you have read the above disclosure statement, agreement, understand your responsibilities and agree to these terms.

Patient Name (Please Print):_____

Responsible Party Name (Please Print):_____

Patient/Responsible Party Signature: _____ Date:_____