EXPRESS CARE
OF BELLEVIEW / LEESBURG
URGENT CARE & FAMILY PRACTICE

10762 S.E. U.S. Hwy. 441
Belleview, 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. # _____

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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 practioner 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 occured: ☐ 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 occured): ☐ 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
Mumps _____ no yes
Chickenpox _____ no yes
Whooping Cough __ no yes
Scarlet Fever _____ no yes
Diphtheria _____ no yes
Smallpox _____ no yes
Pneumonia _____ no yes
Pheumatic Fever ___ no yes
Heart Disease _____ no yes
Arthritis _____ no yes
Venereal Disease ___ no yes
Anemia _____ no yes
Bladder Infections _ no yes
Epilepsy _____ no yes

Migraine headaches no yes
Tuberculosis _____ no yes
Diabetes _____ no yes
Cancer _____ no yes
Polio _____ no yes
Glaucoma _____ no yes
Hernia _____ no yes
Blood or Plasma ___ no yes
transfusions
Back trouble _____ no yes
High or low blood __ no yes
pressure
Hemorrhoids _____ no yes
Date of last chest x-ray _____
Asthma _____ no yes

Hives or Eczema ___ no yes
AIDS or HIV + ____ no yes
Infectious Mono ___ no yes
Bronchitis _____ no yes
Mitral Valve Prolapse _ no yes
Stroke _____ no yes
Hepatitis _____ no yes
Ulcer _____ no yes
Kidney Disease ____ no yes
Thyroid Disease ___ no yes
Bleeding tendency _ no yes
Any other disease __ no yes
(please list) _____
_____
_____

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

			Relationship				Relationship
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)

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

	Present age, or age of death	If living, health (good, fair, poor) If deceased, cause of death
Father		
Mother		
Siblings		
Spouse		
Children		

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

EXPRESS CARE
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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.