

**PATIENT DEMOGRAPHICS**

Welcome to our office! We look forward to caring for you. To better serve you, please complete the information below. This form will be updated annually.

NAME: Last \_\_\_\_\_ First \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security \_\_\_\_/\_\_\_\_/\_\_\_\_ Male  Female

Marital Status: Single Married Partnered Widowed

Occupation: \_\_\_\_\_

Local Address: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell # (\_\_\_\_) \_\_\_\_\_ Home # (\_\_\_\_) \_\_\_\_\_

Email address: \_\_\_\_\_

May we enroll you in our Patient Portal to have secure online access to your medical records? yes  no

Are you a seasonal visitor of Florida?  yes  no

If yes who is your PCP at home? Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Race:  Asian  Black/African American  White  Native Hawaiian/Other Pacific  Other: \_\_\_\_\_

Ethnicity:  Hispanic or Latin American  Non-Hispanic or Latin American  Decline to Specify

EMERGENCY CONTACT NAME: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

I give permission to Dr. Saccente and his staff to discuss my medical case with my Emergency Contact and the following people only (include name, relation and phone number): \_\_\_\_\_

PHARMACY NAME: \_\_\_\_\_ CITY: \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

PRIMARY INSURANCE COMPANY: \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

SECONDARY INSURANCE COMPANY: \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

*Authorization to Pay Benefits to Physician: I hereby authorize payment directly to the physician of medical benefits. I understand I am responsible to pay for non-covered services. I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

Michael D. Saccente D.O.  
1251 Lakeview Road  
Clearwater, FL 33756  
www.dr Saccente.com  
Tel: (727) 544-9326 Fax: (727) 544-9601

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#### **GENERAL INFORMATION:**

Our office hours are from 9 a.m. to 5 p.m. Monday through Thursday and 9 a.m. to noon on Friday. The office is closed 12:00-1:00 daily for lunch. The Provider's in-office schedule varies from these hours as we also provide patient care at Morton Plant Hospital. For urgent medical issues that cannot wait until regular business hours please call (727) 544-9326 and page the on-call doctor. If you are experiencing a medical emergency call 911.

**PAYMENTS AND BILLING:** Payment *in full* is expected at the time of visit prior to being seen by the Provider unless other arrangements have been made in advance. We accept cash, check, Visa and MasterCard payments. We will send a statement to you should you have a balance with our office. If no payment is made within 30 days an additional statement will be mailed. After three consecutive statements the patients account will be sent to an outside collections agency and permanently discharged from the practice. If collections become necessary, the patient may incur additional fees. If you have questions about a bill please call our billing company, Practice Forces, at 727-683-0428.

**INSURANCE:** We file any insurance with which we have a contract. Please present your insurance card at each appointment prior to seeing the Provider. If you have changes to your health care coverage please notify our office prior to being seen by the Provider.

#### **OFFICE VISITS:**

- **By appointment only:** Office visits are by appointment only, no walk-ins.
- **Scheduling:** The nature of our practice is to give our patients the best possible care and service. Please be assured you will be attended to as promptly as possible.
  - Routine physicals and similar types of appointments will be scheduled for two weeks or more from the time requested.
  - Semi-urgent appointments will be scheduled within at least 1 week from the time requested.
  - Urgent care issues are seen the same day when the doctor is in-office.
- For **new patients**, please arrive 30 minutes prior to your scheduled appointment for registration. If you are an **established patient**, please arrive 10 minutes prior to your scheduled appointment time and bring your driver's license and insurance card as they will need to be scanned into our electronic health record.
- **No-Show:** A no-show appointment without cancellation within a 24-hour period will result in a \$50.00 charge. After three no-show appointments the patient will be discharged from the practice.
- **Patients must be seen for a face-to-face appointment with the Provider at least once during every 12 month period in order to remain an active patient with our office.** After 12 months the patient will be placed as "inactive" and after 3 years they will be considered a new patient.
- We ask that patients visiting our office who have symptoms of or recent exposure to upper respiratory viruses or any contagious virus including COVID-19 to please wear a mask for patient and staff safety.

### **PHONE CALLS:**

- It is important to us that all calls are answered promptly. If we are unable to take your call please leave a detailed message and phone number and one of our office staff will return your call **by the end of the work day.**
- Physicians are on call 24 hours a day seven days a week for medical emergencies that cannot wait until regular business hours. Please call (727) 544-9326 and page the on-call doctor. **If you are experiencing a medical emergency call 911.**

**RESULTS:** Most lab and diagnostic test results are returned to our office within 72 hours. **We will notify patients of results once they are received and Dr. Saccente has reviewed them.** We are not able to provide results ordered by other providers. If results are abnormal, changes in prescriptions are needed, or if the Provider wished to discuss the results directly with the patient, we will schedule a follow-up appointment.

**PRESCRIPTIONS:** If you need a refill, **please contact your pharmacy.** Please take note of our office hours as the Provider does not send prescription refills after business hours. **No prescriptions will be filled for patients who have not been seen within the last 12 months.**

- **Controlled Prescriptions:** In 2018, the State of Florida implemented HB21. Dr. Saccente has Controlled Substance Policies in place that ensure our patients' safety as well as our office's adherence to the Florida prescription drug laws. Per S.456.44(3)(d) **ALL** patients on a Schedule 2, 3, 4 or 5 medication must be seen by the Provider *at least* every 90 days.
- Please report any medication changes made by other Providers to our office so we can ensure your quality of care.

**REFERRALS:** If your insurance company requires an authorization or referral in order to see a specialist please notify our office at least one week prior to your appointment. We obtain referrals as soon as possible. Due to the increased requirements of insurance companies and the Prior Authorization process, it may take up to 5-10 business days to complete a referral.

**RECORDS:** We will provide another provider with your medical records after receiving a signed consent of release. Per HIPAA, we will only discuss your health care with specifically covered entities that the patient has permitted our office to share information with that is directly relevant to the involvement of a spouse, family members, friends, or other persons identified by a patient, in the patient's care or payment for health care.

**FORMS AND LETTERS:** Please allow seven to ten business days for patient requested paperwork and letters to be complete. A \$25.00 service fee is required for all patient requested forms and paperwork.

**ADVANCE DIRECTIVES:** If you have signed Advance Directives, have a Living Will or have designated a Health Care Surrogate please provide our office with a copy.

By signing below, I attest that I have read and understand the above Office Policies. If at any point clarification is needed, I will contact the Office Manager, Julie Saccente.

Print: \_\_\_\_\_

Sign: \_\_\_\_\_

Date: \_\_\_\_\_

## CURRENT MEDICAL CONDITIONS

**NAME:** \_\_\_\_\_

Please check if you are having any of these problems at this time.

GENERAL	EYES
Fever	Glasses contacts or lasix surgery
Anemia	Discharge
Swollen glands	Pain
Undue tiredness	Blurred vision
Weight loss	Glaucoma
Weight gain	Cataracts
HEAD	EARS
Headaches	Hearing loss
Fainting spells	ringing
Hair changes	Pain
Seizures	Discharge
Lumps or bumps that seem abnormal	Piercing
NECK	NOSE
Goiter	Bleeding
Thyroid problems	Snoring
Stiffness	Drainage
Pain	Sneezing
BREAST	MOUTH
Lumps	Sore throat
Discharge	Swallowing difficulty
Change in skin color	Hoarseness
CHEST	Ulcers
Cough	Cavities
Phlegm [ ] colored [ ] clear	Caps
Pain chest or back	Pain
Blood in mucus	Dentures
Wheezing	UROLOGY
Unable to lay flat	Pain or burning when passing urine
Chest pain on exertion	Blood in the urine
Short of breath at rest	Passing air or fiber material in urine
Short of breath with exertion	Urination at night & frequency
>2 pillows to sleep on	Pain with sexual intercourse
Ankles swelling	Leaking of urine
Palpitations or irregular heart beat	Testicular lump or abnormality
	Lesions on or around the genitalia

GI	EXTREMITIES
Heartburn	Varicose vein
Nausea	Blood clot in arm or leg
Vomiting	Paralysis or arm, leg or body part
Vomiting blood	Weakness of arm, leg or body part
Diarrhea	Numbness of arm, leg or body part
Recent antibiotic use	Pain on walking
Constipation	Feet problems
Pale stool	Ankle problems
Upper right abdominal pain	Knee problems
Upper left abdominal pain	Hip problems
Lower right abdominal pain	SKIN
Lower left abdominal pain	Abnormal or growing moles
Food intolerance/ allergy _____	Bleeding moles
PSYCH	Rashes
Suicidal thought	Lumps
Suicidal plan	Easy bruising
Self mutilation (cutting,scratching)	Psoriasis
Have you been sexually assaulted	Eczema
Is your home environment safe	Burn easy when out in the sun
Any verbal abuse towards you	Use sunscreen
Spousal abuse	Problem with surgical wound
Depression	Cut heals abnormally (Keloid)
Anxiety	Piercing location _____
Difficulty with sleeping	Tattoos location _____
	Hair implantation method _____
	Hair removal method _____
	Skin infection with MRSA (resistant bacteria)

## PAST MEDICAL HISTORY

Past medical history X if you have had any of the following in the past:

High cholesterol	Appendectomy
Heart attack	Tonsillectomy
Peripheral vascular disease	TABHSO Hysterectomy with ovaries removed
Coronary artery disease	Hernia repair inguinal side
Hypertension	Hemicolectomy
Stroke	Cholecystectomy (gallbladder removed)
TIA	Abdominal aorta Repair
Diabetes type I	Heart metal valve replaced
Diabetes type II	Heart nonmetal valve replaced
Hypothyroidism	Coronary artery bypass surgery
Hyperthyroidism	Hemorrhoid surgery
Thyroid or parathyroid problem	Sinus surgery
Lupus	On chemotherapy currently
Emphysema (COPD)	Thyroid surgery
Asthma	Breast surgery if so why
Environmental allergies	Genital urinary surgery
Esophageal reflux	Polyps removed from colon
Ulcers Where	Abdominal surgery
Low back pain	Joint replacement surgery which
Insomnia	Motor vehicle accident Last 5 years
Sexually transmitted disease	Brain surgery
Osteoporosis	Thyroid surgery
HIV date Viral load CD4	Neck or back surgery
Prostate enlargement	Tubal Ligation
Cancer	Usual childhood disease
Pneumonia	Hepatitis B vaccination when
Endometriosis	Hepatitis A vaccination When
Osteoarthritis	Tetanus vaccination When
Rheumatoid arthritis	Travel outside the continental US
Diverticulitis	Colon cancer
Diverticulosis	Prostate cancer
Renal Failure	Blood clot to the legs or arms
Blood clots to the lungs	Do you have a port Where
Have you ever had meningitis	Have you ever had tuberculosis
Have you ever had exposure to Tuberculosis	Do you have a port Where
Have you recently taken antibiotics	Have you been treated in the past for C-Diff
Have you been treated For MRSA or a resistant bacteria	
Have you ever had tuberculosis	
Have you been treated for tuberculosis	

**UNIVERSAL PATIENT AUTHORIZATION FORM FOR  
FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND QUALITY OF CARE**

**\*\*\*PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW\*\*\***

**Patient (name and information of person whose health information is being disclosed):**

Name (First Middle Last): \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.**

**By signing this form, I voluntarily authorize, give my permission and allow use and disclosure:**

**OF WHAT:** ALL MY HEALTH INFORMATION including any information about sensitive conditions (if any) [See page 2 for details]

**FROM WHOM:** ALL information sources [See page 2 for details]

**TO WHOM:** Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name: Michael D. Saccente, DO Phone: (727) 544-9326

Address: 1251 Lakeview Rd. Clearwater, FL 33756 Fax: (727) 544-9601

**PURPOSE:** To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

**EFFECTIVE PERIOD:** This authorization/permission form will remain in effect until my death or the day I withdraw my permission.

**REVOKING MY PERMISSION:** I can revoke my permission at any time by giving written notice to the person or organization named above in "To Whom."

**In addition:**

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].
- I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.
- I have read all pages of this form and agree to the disclosures above from the types of sources listed.

**X**

\_\_\_\_\_  
Signature of Patient or Patient's Legal Representative

\_\_\_\_\_  
Date Signed (mm/dd/yyyy)

\_\_\_\_\_  
Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

Parent of minor

Guardian

Other personal representative (explain: \_\_\_\_\_)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.



## HIPAA NOTICE OF PRIVACY PRACTICES

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Michael D. Saccente, D.O.  
1251 Lakeview Rd.  
Clearwater, FL 33756  
Phone: (727) 544-9326 Fax: (727) 544-9601  
[www.drsaccente.com](http://www.drsaccente.com)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This Notice of Privacy Practices described how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

### Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: public health issues as required by law, communicable diseases, health oversight, abuse or neglect, Food and Drug administration requirements, legal proceedings, law enforcement, coroner, funeral directors, organ donation research, criminal activity, military activity and national security,

Workers' Compensation, inmates: required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

**You may revoke this authorization**, at any time, in writing except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights** Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records: psychotherapy note, information compiled in reasonable anticipation of or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternate means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints** You may complain to us or to the secretary of Health and Human services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our office manager of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on or before July 1, 2005.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protecting health information. If you have any objections to this form, please ask to speak with our HIPAA compliance officer in person or by phone at our main phone number.

**Signature below is only acknowledgement that you have received this notice of our practices:**

**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

Michael D. Saccente D.O.  
1251 Lakeview Road  
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www.drscaccete.com  
Tel: (727) 544-9326 Fax: (727) 544-9601

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It is our office policy that if any patients of Michael D. Saccente, D.O. choose to leave any hospital against medical advice, regardless of the physician on call, then this patient will be discharged from our practice with thirty (30) days notice. This policy is necessary to ensure the best continuity of care for our patients. We cannot in good conscience care for patients who are medically noncompliant. There will be no exceptions to this office policy.

By signing this form you acknowledge that you have received and understand this policy. If you have any questions please contact the office manager, Julie Saccente.

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Signature of Patient

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Date