PATIENT DEMOGRAPHICS

Welcome to our office! We look forward to caring for you. To better serve you, please compete 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 ☐Hispanic ☐Native Hawaiian/Other Pacific ☐Other: _____
Ethnicity: ☐Hispanic or Latin American ☐Non-Hispanic or Latin American ☐Decline to Specify

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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 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.drsaccente.com
Tel: (727) 544-9326 Fax: (727) 544-9601

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. 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.

- **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 Trish in the billing department at 727-532-6900.

- **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.

- Due to the ongoing COVID-19 emergency we are following CDC guidelines, including wearing masks and social distancing in the office.

- **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 patent, 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 not discuss your health care with anyone who is not listed on your contact list.

- **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: _____

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
	Osteoperosis		Thyroid surgery
	HIV date : Viral load _____ CD 4 _____		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 out side 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		

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)	

THIS FORM SHOULD ONLY BE USED WHEN REQUESTING PATIENT HEALTH INFORMATION FROM OUTSIDE HEALTHCARE PROVIDERS.

AUTHORIZATION FOR THE REQUEST OF PATIENT HEALTH INFORMATION FROM OUTSIDE HEALTH CARE PROVIDERS

Please Print Clearly

Patient Name: _____ Date: _____

Date of Birth: _____ Last 4 digits SSN: _____ I,

_____, **hereby request and authorize the release of the following records**

from: _____

(Facility/Physician PHI requested from) **Phone Number**

_____

Street/PO Box **City** **State** **Zip Code**

☐ **MRI Reports**	☐ **OP Report**	☐ **Consultation**
☐ **MRI Films**	☐ **Discharge Summary**	☐ **Pathology**
☐ **X-Ray Reports**	☐ **Office Notes**	☐ **Cardiology**
☐ **X-Ray Films**	☐ **EMGs**	☐ **Complete Medical Record**

Other: _____

This release of information is for continuity of care, unless otherwise noted: _____

My Records may contain the following and, **unless crossed out and initialed**, I specifically authorize their release:

HIV Test Results (Test for AIDS) **AIDS Related Records** **Drug or Alcohol Records** **Tuberculosis Records**
STD Records (Sexually Transmitted Diseases) **Mental Health Records** **Pregnancy Records**

TO: Michael D. Saccente, D.O.

Full Name/Location of Recipient of Your Records

1251 Lakeview Rd.

Street/PO Box

Clearwater	FL	33756
City	State	Zip Code
727-544-9326	727-544-9601	
Telephone Number	Fax Number	

Patient or Authorized Signature: _____ **Date:** _____

Relationship to Patient: _____

Explain and/or attach Legal Documentation

Pursuant to Florida law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, the record may be given only to the person designated, and it may be used only for the purpose listed on this form. Charges are in compliance with Florida law. I understand that once my information is disclosed to the recipient above, it may be redisclosed to individuals not subject to HIPAA and may no longer be protected by HIPAA. I understand that signing this authorization is voluntary and will not affect my receipt of treatment. I understand that I may revoke this authorization at any time, in writing, to the address listed above provided that the information has not yet been released. This authorization expires in twelve (12) months unless another date is written here _____.

___X__PLEASE SEND RECORDS REQUESTED ASAP, AS THIS IS FOR IMMEDIATE PATIENT CARE. THANK YOU. Fax 727-544-9601

Revised 1/20/2022

MEDICATION CHART

DATE:_____

PATIENTS NAME:_____

Help us care for you better by telling us what prescriptions and over-the-counter medication you take.

Name of Medications	Dosage	How many times a day and when do you take it?	Name of Doctor who prescribed the medication.	Reason why you take this medication.

HIPPA NOTICE OF PRIVACY PRACTICES

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

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. It 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.

_____ _____

Signature of Patient Date

_____ _____

Witness Date