

EXPRESS CARE OF LAKE COUNTY
CELESTINO D. SANTI, D.O. PA

AUTHORIZATION FOR USE OF OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I _____ hereby authorize Express Care of Lake County its affiliates, employees or agents to _____ release _____ obtain copies of the medical records.

To / From _____
Name of Individual, Healthcare Facility or Agency Fax &/or Phone Number

Address _____ City _____ State _____ Zip Code _____

For the purpose of : _____ Continued Treatment _____ Personal Records
Other (Please Specify) _____

If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Mental Health, Alcohol, Drug, HIV &/or AIDS information is confidentially protected by Federal & State Law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/ testing information in the information from the list below to be released by placing my initials in the space provided. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized redisclosure of my health information.

Information to be released or obtained includes : **Place your initials by each item that applies.**

_____ Mental Health _____ Psychotherapy Notes _____ AIDS Information
_____ Drug &/or Alcohol _____ HIV Testing _____ Genetic Counseling/ Testing Information

The Specific records to be released or obtained are: **Initial item that applies and specify date to be sent.**

_____ Complete Record From _____ To _____
_____ All Diagnostic Test Results ONLY From _____ To _____
_____ Pathology/Operative Report(s) ONLY From _____ To _____
_____ Lab ONLY From _____ To _____
_____ Other (please specify what & Time Period) _____

_____ (signature) _____ (Date of Auth)
Patient/ Legal Representative or Parent / Legal Guardian

_____ (Social Security Number) _____ (Date of Birth)

Address: _____ (Telephone #)

Witness: _____ (Date)

OFFICE USE ONLY:

NAME OF PERSON RELEASING INFORMATION DATE # OF PAGES

2020 NIGHTINGALE LANE * TAVARES, FL 32778 * (352) 742-1500 FAX (352) 742-9024

CELESTINO D. SANTI, DO, PA

2020 NIGHTINGALE LANE

TAVARES, FL 32778

MEDICARE PATIENTS PLEASE READ AND SIGN:

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO DR. SANTI FOR ANY SERVICES FURNISHED ME BY THAT PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

PATIENTS SIGNATURE X _____

MEDICARE WITH MEDIGAP POLICY PLEASE READ AND SIGN:

I REQUEST THAT PAYMENT OF AUTHORIZED MEDIGAP BENEFITS BE MADE ON MY BEHALF TO DR. SANTI FOR ANY SERVICES FURNISHED ME BY DR. SANTI. I AUTHORIZE ANY HOLDER OF ANY INFORMATION ABOUT ME TO RELEASE TO (NAME OF MEDIGAP INSURER) _____ ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

PATIENTS SIGNATURE X _____

PRIVATE INSURANCE POLICY HOLDERS PLEASE READ AND SIGN:

I AUTHORIZE PAYMENT OF INSURANCE BENEFITS BE MADE ON MY BEHALF TO DR. SANTI FOR SERVICES FURNISHED BY DR. SANTI. I AUTHORIZE ANY HOLDER OF ANY INFORMATION ABOUT ME TO RELEASE TO (NAME OF INSURANCE CO.) _____ ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

PATIENTS SIGNATURE X _____

I UNDERSTAND I AM RESPONSIBLE FOR ANY COPAYMENTS OR AMOUNTS NOT COVERED BY MY INSURANCE

PATIENTS SIGNATURE X _____

AS A PATIENT AT EXPRESSCARE OF LAKE COUNTY ...

- I understand that the Medical providers at ExpressCare of Lake County are Kim Balogh, PA-C (Physician's Assistant) and Dianne Copenhaver ARNP (Nurse Practitioner) and all Medical care is supervised by Dr. Celestino Santi, D.O.
 - I understand that controlled substances are not routinely prescribed at this facility and if they are prescribed, it is for acute pain on a short term basis ONLY. If I fail to comply with this rule, I can be discharged from this practice.
 - I understand that I must bring all medication vials to each office visit that I am currently taking or am prescribed in order to keep accurate and up to date records.
 - I understand that this facility is unable to perform in-house laboratory testing, and certain diagnostics and therefore, after I am evaluated by the provider, I still may be sent to the Emergency Room for further evaluation and treatment as deemed necessary. (i.e...if I have chest pain, abdominal pain, shortness of breath, or any condition that requires immediate treatment, diagnostics and results, I may end up in the ER any way.)
 - I understand that I am expected to follow and carry through the orders of the medical providers and ECLC's staff in order to remain a patient at BCLC. If I fail to do so, not only will I be expected to sign a form that I am acting against medical advice, but I may be discharged from the practice.
 - I understand that it is solely my responsibility to keep BCLC up to date with my current address, telephone number, and insurance information, and I take full responsibility for any charges incurred if I fail to do so.
-
- I understand that patients assistance for medications is done as a courtesy. It is not to be expected and can be terminated at any time. I must cooperate with office visits, testing, paperwork, etc... in order to receive this service.

PATIENT SIGNATURE

DATE

CELESTINO D. SANTI, DO, PA
2020 NIGHTINGALE LANE
TAVARES, FL 32778

PATIENT INFORMATION

(PLEASE PRINT)

Patient Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Cell _____

Date of Birth _____ Age _____ Sex () male () female

Marital Status () married () single () divorced () widowed SS# _____

Employer (if applicable) _____ Phone _____

Address _____ City _____ State _____

GUARANTOR INFORMATION

(For parents seeking treatment for children, or Power of Attorney seeking treatment for persons in your custody)

Guarantor _____ Relation to Patient _____

Address _____ City _____ State _____

Phone _____ SS # _____ DOB _____

By signing as Guarantor, I understand that I am seeking care for the above named person and accept full financial responsibility for any co-pays, co-insurance, deductibles, or any other amount not covered by insurance.

Signature

Date

INSURANCE INFORMATION

Please fill out the information of the primary policy holder for you insurance and present card for photocopy at front desk

Insurance Co _____ Policy # _____

Insured's Name _____ DOB _____

SS # _____ Relation to patient _____

COMPREHENSIVE HISTORY AND PHYSICAL

NAME _____ D.O.B. _____ M.R.# _____

CHIEF COMPLAINT _____

MEDICATION ALLERGIES _____

PRESENT MEDICATIONS AND DOSAGE _____

PAST MEDICAL HISTORY

MEDICAL PROBLEMS _____

OPERATIONS _____

ALCOHOL CONSUMPTION _____ TOBACCO USE _____

FAMILY HISTORY

ANY MEDICAL PROBLEMS WITH FAMILY ?

FATHER _____

MOTHER _____

SPOUSE _____

CHILDREN _____

BROTHERS \ SISTERS _____

DR. CELESTINO D. SANTI

REVIEW OF SYMPTOMS

DO YOU HAVE ANY OF THE FOLLOWING? :

1. SWOLLEN GLANDS, SKIN RASH: _____
2. DIFFICULTY URINATING, URINATING AT NIGHT, BURNING ON URINATION, URINARY INCONTINENCE: _____
3. CHRONIC COUGH, SHORTNESS OF BREATH WITH ACTIVITY, HISTORY OF TUBERCULOSIS: _____
4. HEARTBURN, DIFFICULTY SWALLOWING, ABDOMINAL PAIN, FREQUENT AND/OR CHRONIC CONSTIPATION OR DIARRHEA, RECTAL BLEEDING, FREQUENT NAUSEA/VOMITING, DAILY FEVER, RECENT CHANGE IN WEIGHT, NIGHT SWEATS: _____
5. CHEST PAINS, SHORTNESS OF BREATH, SWELLING IN LEGS OR FEET, PALPITATIONS: _____
6. HEADACHE, BLURRED VISION, DOUBLE VISION, WEAR GLASSES, RINGING IN EARS, DIFFICULTY HEARING, USE A HEARING AID, HOARSENESS, SORE THROAT, NASAL CONGESTION, OR ALLERGIES: _____
7. THYROID PROBLEMS, OR DIABETES: _____
8. MENTAL OR PSYCHIATRIC PROBLEMS: _____
9. FEMALES: HOW LONG IS YOU MENSTRUAL CYCLE? _____
 IS IT HEAVY, LIGHT, OR MODERATE? CHILDREN _____
 MISCARRIAGES _____ ABORTIONS _____ METHOD OF BIRTH CONTROL _____

HEALTH MAINTENANCE

<u>DATE</u>	<u>PHYSICAL EXAM</u>	<u>PAP/PELVIC</u>	<u>CXR</u>	<u>EKG</u>	<u>MAMO</u>	<u>STOOL</u>