Carl Saladino, M.D. / Suntree Medical Associates, P.A.

Patient Name____ Date of Birth_______________

Address____ Home Phone#______________

____ Cell Phone# _______________

Email: ____ Work Phone# ______________

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Male / Female SS# ______________ Race: _________ Ethnicity: __Latino/Hispanic
__Other

___Single ___Married ___Student ___Other Primary language____________

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Do you have a: (if YES, you MUST provide our office with a copy for your medical record)

Living Will _______ **Power of Attorney**______ **Health Care Surrogate**_______ **DNR** order______

Please initial here if you give your permission for our staff to leave a voice message with normal test results. This does not take the place of any scheduled review appointment. **Call#** _____________ **Initial**________

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Emergency Contact:

1.Name: __________________________ Relationship___________ Phone # ________________________

2.Name: __________________________ Relationship___________ Phone # ________________________

Local Pharmacy: ____________________ Crossroads__________________ Phone________________

Mail Away Pharmacy: ___________________________ Phone: __________________

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Insurance: ________________ ID# _________________ Group#______________Phone_____________

Effective Date: ______________ Policy Holder Name & birthdate________________________________

Secondary: ________________ ID# _________________ Group#______________Phone_____________

I assign all medical benefits to which I am entitled to Suntree Medical Associates for services rendered. A photocopy of this assignment is to be considered as valid and original. The assignment will remain in effect until revoked by me in writing. I understand it is my responsibility to know the details of my insurance, including coverage, participating labs, diagnostic imaging centers, specialists, and hospitals. I understand I am responsible for deductibles, co-pays and coinsurance which will be collected at the time of service. I understand that I am ultimately financially responsible for all charges whether or not approved for paid for by my insurance company. I authorize the release of any medical information or medical records regarding my treatment to my insurance company to help secure payment for services rendered and to any of my healthcare providers for coordination of care. I understand secondary insurance plans are billed as a courtesy and it is my responsibility to follow up with the secondary payer for reimbursement. I agree to have available cash, check, debit or credit card to satisfy any and all balances deductibles co-pays and coinsurance at the time of service.

Patient Initial: ____________

Patient Responsibilities:
*All patients are responsible for re-scheduling any canceled appointments, especially those to review tests that were performed.
*All patients are responsible to know the details of their insurance, including: coverage, participating labs, diagnostic imaging centers, specialist & hospitals.
*IT IS NOT OUR OFFICE POLICY TO GIVE TEST RESULTS OVER THE PHONE. AN APPOINTMENT WILL BE NEEDED TO REVIEW TEST RESULTS.
***** I understand that copay's, co-insurance, deductibles, and non-covered charges, I am financially responsible for at the time of service
***Last minute cancelation or NO SHOW for appointments will result in a NO SHOW FEE applied to your account and due before date of next visit.**

Patient Signature: _____ **Date:** _____

Witness Name Printed:_____ Signature: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis sees, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for

- planning my care and treatment
- a means of communication among many health professionals who contribute to my care
- a source of information for applying my diagnosis in surgical information to my bill
- a means by which the third-party payer can verify that services billed were actually provided
- a tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals.

I acknowledge that I have been provided with and understand Suntree Medical Associates *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that Suntree Medical Associates may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of Suntree Medical Associates *Notice of Privacy Practices* by submitting a request in writing for a current copy of Suntree Medical Associates *Notice of Privacy Practices*.

_____

Printed Patient Name Patient Signature Date

If patient Representative:

_____ _____

Printed Patient Personal Representative Name Relationship to Patient

_____ _____

Patient Personal Representative Signature Date

Patient Initial: _____

Carl Saladino, M.D.
Suntree Medical Associates
(321) 757-9711

Notices, reminders, information, instructions and disclaimers from Suntree Medical Associates, the office of Carl Saladino, M.D including SMA Nurse Practitioners and Physician Assistants. By signing below, patients of Suntree Medical Associates acknowledge that they have read, had the opportunity to ask questions about, provided with answers to their satisfaction and given a copy of this notice if requested.

1. We recommend annual history and physicals or medical reviews to discuss any symptoms, medical problems, medications and any other medical issues whatsoever in detail. Patient will inform the doctor, nurse practitioners, or physician assistants of any concerns, complaints or symptoms. If questions are not answered to patient satisfaction or symptoms persist, the patient will again notify the staff and Dr. Saladino of the symptoms and situation to be pursued further and more aggressively.
2. The patient understands that Dr. Saladino and staff from time to time may make recommendations including suggestions of testing, consultations, referrals or other forms of care which the patient may decline for various reasons. The patient agrees that Dr. Saladino, Nurse Practitioner's, Physician Assistants and all of the staff make notations in the record that they suggested and explain a medical recommendations/test but it was declined by the patient, will be sufficient to acknowledge the patient's acceptance of responsibility for their decision-making and the fact that this could lead to delay and diagnosis or inability to diagnose at times potentially life-threatening or dangerous medical conditions.
3. The patient agrees to keep Dr. Saladino's office aware of updated medication and allergy lists. Dr. Saladino also recommends that the patient carry a list of both prescription and over-the-counter products including supplements, aspirin tablets and vitamins with any drug related allergies also listed.
4. Dr. Saladino also recommend his female patients age 40 and above see a gynecologist/ or one of our Nurse Practitioner's or Physician Assistants annually for complete breast, rectal and vaginal examination with mammograms Pap smears and hemoccults provided by the gynecologist office or our office. We may occasionally offer hemoccults here in our office. Female patients acknowledge that they are aware routine or other gynecologic care in is available in our office is provided by our Nurse Practitioners. Dr. Saladino does not do routine or other gynecologic care. Women under the age of 40 should also consider gynecologic care if they have questions about birth control, family or personal history of breast or any gynecologic abnormalities are cancers. All female patients are also reminded to perform monthly self-breast exams and keep their gynecologist as well as Dr. Saladino and our staff aware of any suspicious abnormalities. Our office also provides requisitions for DEXA bone scan for various women at age 50 or above for evaluation of potential osteoporosis or management of osteoporosis conditions. Our female patients acknowledge that they will seek this test at a local imaging facility, there gynecologist office or elsewhere. If patients have any questions they should feel free to speak to our staff or Dr. Saladino directly.
5. For our male patients we typically recommend, from age 50 and above, annual PSA blood test levels for Prostate Cancer evaluation.
6. For ALL patients, please bring to our attention any change in bowel or urine habits, black stool, and blood in stool, nighttime urinary frequency, and bowel or urine incontinence. Patient is aware that they may request digital rectal exams with annual checkups or other times if any concerns.
7. Diabetic patients acknowledge awareness of the need for annual eye doctor and foot Dr. routine care and monitoring. Also blood sugar testing approximately every three months and adherence to American Diabetic Association diet and guidelines. Diabetic patients are encouraged to do finger stick blood sugar

monitoring at home. Our staff is happy to help assist. Any questions should be directed to staff or Dr. Saladino.

8. High cholesterol patients acknowledge awareness of proper low that diet and guidelines. If on statins/cholesterol-lowering medications, patients will make Dr. Saladino and staff aware of any side effects including muscle aches and pains and memory loss. Patients with high cholesterol agree to have blood testing to monitor cholesterol and if on medication for cholesterol lowering, agree to regular blood testing for monitoring and adjustment in treatment.
9. Patient acknowledges awareness of Dr. Saladino's recommendation at age 50 and above to seek gastroenterology consultation for colon cancer evaluation, consideration of colonoscopy and other gastrointestinal workup, age 40 and above if family history of colon cancer.
10. The patient knowledges that this notice is not meant to be all-inclusive. There are many other medical recommendations and guidelines that will be provided verbally in the exam room by the doctor and the staff. The patient will also get further advice and guidance from consultants and other sources of health information.
11. Patients acknowledge that they are aware that medical services and testing offered in Dr. Saladino's office is available elsewhere in the community. I agreeing to have a test in our office the patient acknowledges that this is being done of their own free will and they have no interest in having these tests performed elsewhere.
12. By agreeing to have any testing in our office, patients acknowledge that they have had the test explained to them and agree with the preceding with this test.
13. ***"Call us 1st"*** - if you have an urgent medical need, and you feel it does not require a 911 phone call, please call our office before going to an urgent care, and/or possibly the ER. Our providers are able to offer you same day or next day appointments.
14. If unable to reach Dr. Saladino after hours, on weekends or any other time, patient acknowledges they have easy access and will pursue local walk-in clinic or hospital emergency room care.
15. If Dr. Saladino or staff request the patient have a test performed in our office or elsewhere, patient accepts responsibility for having the test/procedure performed. If test is not performed within 2 weeks of request patient must notify Dr. Saladino. Patient accepts full responsibility for delay in diagnosis or inability to diagnose potentially life-threatening medical conditions if they do not follow requests or recommendations. Patient also accepts response ability for receiving and/or obtaining results of the tests. Patient agrees to have results of all tests ordered/ performed by Dr. Saladino, explained to them to their satisfaction. If patient is not informed of test results they agree to call the office and make an appointment to review.
16. Patients are reminded to develop an exercise program to increase heart rate like brisk walking, treadmill, stationary or regular bike riding and swimming as tolerated. Asked Dr. Saladino if you have any questions.
17. Patient acknowledges that they may be offered visits with the Nurse Practitioners/Physician Assistants and they may ask for Dr. Saladino or a different Nurse Practitioner/Physician Assistant at any time.
18. Patient acknowledges that Suntree Medical Associates / Dr. Carl Saladino reserve the right to discharge a patient at any time if the patient is non-compliant or loud and abusive to the staff of Suntree Medical Associates, P.A. or refuses care and advice. This will be solely determined by Dr. Saladino.
19. Patient agrees to be responsible for all costs and charges incurred while receiving medical care and testing at Suntree Medical Associates. Patient is aware insurance may not cover all costs and patient is responsible for asking about any and all charges. Patient is responsible for being aware of their insurance coverage, deductibles, copay's and balances.
20. Patients receiving care for motor vehicle accident injuries agree that they will be responsible for all charges/ cost related to care provided at Suntree Medical Associates. Patient is aware that at times PIP

insurance may have copay's or only cover part of costs and patient agrees to be financially responsible for any and all balances. Patient agrees that if a letter of protection is provided by their attorney is not sufficient to cover charges incurred at the office of Suntree medical Associates/ Carl Saladino, M.D., patient agrees to be financially responsible for any and all balances. If no letter of protection is offered or provided by the patient's attorney, patient agrees to direct attorney to pay all charges incurred at Suntree Medical Associates/Carl Saladino, M.D. out of settlement proceeds prior to disbursement. If disbursement of settlement funds occurs without Suntree Medical Associates/ Carl Saladino, M.D. knowledge, patient agrees to be personally responsible to balances due to Suntree Medical Associates.

Patient Name Printed: _____

Patient Signature: _____ Date: _____

Witness Name Print: _____

Witness Signature: _____ Date: _____

Suntree Medical Associates
Carl Saladino, M.D.
Internal Medicine and General Practice
6420 3rd Street, Suite 104 (off Suntree Blvd.) Rockledge, FL 32955
Phone: (321) 757-9711 Fax: (321) 253-1675

Authorization for Release of Medical Records

Patient name: _____D.O.B. _____ Last 4 SS#__ __ __ __

Dr. _____Phone: _____ Fax: _____

I authorize the physician/medical group listed above to disclose of any/all records of my treatment, lab results, x-rays, EKGs, or other test reports to Dr. _____

_____.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this is to include any and all federal and state protected information including without limitation of psychiatric, drug and or alcohol abuse, and human immunodeficiency virus test results (AIDS and related conditions).

Requested records from: _____to _____

- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Consultation notes
- ☐ MRI / MRA reports
- ☐ Pathology/ Biopsy reports
- ☐ Lab results_____
- ☐ Radiology Reports
- ☐ Cardiac Testing Reports
- ☐ Colonoscopy / Endoscopy
- ☐ ER records
- ☐ Other: _____

The information for which I am authorizing release of will be used for: ☐ Personal use
☐ Legal purposes ☐ Continued medical care with Dr. Saladino /Suntree Medical Associates.

I understand I may revoke this consent at any time, except to the extent that action has already been taken in reliance on it. I understand the revocation must be made in writing. I also understand that there may be charges associated with the copying of the medical records and agree to pay charges as conditioned by Florida Statute (458.309).

Patient Signature: _____ **Date:**_____

Witness Signature: _____ Printed: _____ Date: _____

Patient Initial: _____

Medical History Questionnaire

Patient Name: _____ D.O.B. _____ Date: _____

Past Medical History
Please list all **P-** for past and **C-** for current medical problems. Please be as thorough as possible.

___ Anemia
___ Anxiety
___ Asthma
___ Blood Transfusion
___ Enlarged Prostate
___ Bronchitis
___ Coronary Artery Dis
___ Cataracts
___ Congestive Heart Failure
___ COPD
___ CVA
___ Depression
___ Emphysema
___ Gallstones
___ Glaucoma
___ Gout
___ Heart Disease
___ Heart Attack
___ Liver Disorders
___ Hepatitis
___ HIV
___ High Cholesterol
___ High Blood Pressure
___ Kidney Stones
___ Leukemia
___ Migraine Headaches
___ Diabetes (insulin dep.)
___ Diabetes (non-insulin)
___ Arthritis
___ Osteoporosis
___ Stomach Ulcers
___ Pneumonia
___ Kidney Failure
___ Seizure Disorder
___ Stroke
___ Thyroid Condition
___ Low Testosterone

Patient's Previous Surgical History Year

_____
_____
_____
_____
_____
_____

Family History

Father: Living / Deceased Age:____
Mother: Living / Deceased Age:____
Brother: #1 Living / Deceased Age:____
#2 Living / Deceased Age:____
Sister: #1 Living / Deceased Age:____
#2 Living / Deceased Age:____
Additional:_____

Family History

	Father	Mother	Brother#1	Brother#2	Sister#1	Sister#2
Alzheimer's	_____	_____	_____	_____	_____	_____
Anxiety Disorder	_____	_____	_____	_____	_____	_____
Coronary Artery Disease	_____	_____	_____	_____	_____	_____
Breast Cancer	_____	_____	_____	_____	_____	_____
Colon Cancer	_____	_____	_____	_____	_____	_____
Prostate Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Endocrine Disorder	_____	_____	_____	_____	_____	_____
Gallstones	_____	_____	_____	_____	_____	_____
Heart Attack	_____	_____	_____	_____	_____	_____
Hyerlipidemia	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Renal Disorder	_____	_____	_____	_____	_____	_____
Respiratory Disorder	_____	_____	_____	_____	_____	_____
Obesity	_____	_____	_____	_____	_____	_____
Seizure Disorder	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Thyroid Disorder	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Social History

Alcohol

Do you drink Alcohol? Yes or No

Drinks per day:
Beer: _____ Wine:_____ Hard Liquor: _____

Occupation:
_____

Smoking or Tobacco Use

Have you ever smoked? Yes or No
Are you still smoking? Yes or No

Packs per day _____
How many years? _____
Quit in what year? _____

Review of Symptoms: Please check any recent or new problems.

Head & Neck
___ Headaches
___ Dizziness
___ Lightheadedness
___ Nasal/Sinus Symptoms

Eyes
___ Vision changes

Throat
___ Sore throat
___ Hoarseness
___ Weak voice

Ears
___ Earache
___ Hearing loss
___ Ringing in ears

Cardiac
___ Chest pain
___ Shortness of Breath
___ Palpitations
___ General swelling

Pulmonary
___ Cough
___ Wheeze
___ Shortness of Breath

Digestive
___ Heartburn
___ Nausea
___ Vomiting
___ Abdominal Pain
___ Bowel Changes

Urinary
___ Urinary burning
___ Urinary Frequency
___ Urinary odor

Skin
___ Rash
___ Skin Lesion

Musculoskeletal
___ Muscle aches
___ Joint swelling
___ Joint stiffness

Neurological
___ Numbness

Medications: _____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies:

_____

_____

Patient Signature: _____ Date: _____

Patient Initial: _____

Suntree Medical Associates

6420 3rd Street, Suite 104 * Rockledge, FL (Off Suntree Blvd.) * (321) 757-9711

Patient Authorization and Consent to Release Medical Information- HIPAA

I _____ D.O.B. _____

Hereby authorize Dr. Carl Saladino, and/or the staff of Suntree Medical Associates to provide any and/or all information pertaining to my medical care including but not limited to all medical records, scheduling and canceling appointments, prescriptions, test results, patient x-ray reports, psychiatric records and HIV results. This consent is for the release of medical information only to the follow:

Name: _____

D.O.B. _____

Relationship to patient: _____

Phone Number: _____

Name: _____

D.O.B. _____

Relationship to patient: _____

Phone Number: _____

Name: _____

D.O.B. _____

Relationship to patient: _____

Phone Number: _____

Name: _____

D.O.B. _____

Relationship to patient: _____

Phone Number: _____

I understand this is not a legal durable power of attorney. I also understand some of the information released may be extremely confidential. I understand that I can revoke this authorization at any time.

Patient Signature: _____ Date: _____

Witness Signature & Print: _____ Date: _____

Patient Initial: _____

Suntree Medical Associates, P.A.

Patient name: _____ Date: _____

Signature:_____

To better facilitate coordination of care, please list names of all your physicians with specialties, their phone number. You are giving SMA permission to share your HIPAA protected medical information with your other physicians.

Allergy/ 1mmunology _____

Cardiology _____

Chiropractor _____

Dermatology _____

Endocrinologist _____

ENT-(Ear. Nose Throat) _____

Gastroenterologist _____

General Surgeon _____

Gynecology _____

Gynecology/Oncology _____

Hematology/Oncology(Cancer Doctor) _____

Infectious Disease _____

Psychiatrist _____

Nephrology (Kidney) _____

Neurology _____

Neurosurgery _____

Ophthalmology _____

Optometry_____

Orthopedic _____

Pain Management _____

Plastic Surgery _____

Podiatry _____

Pulmonary _____

Radiation Oncology _____

Rheumatology _____

Urology _____

Vascular Surgery _____

Patient Initial: _____