DIABETES THYROID & ENDOCRINE ADVANCED CARE

2802 Aloma Ave. • Suite 101 • Winter Park, FL • 32792

PATIENT INFORMATION

Please answer all question fully

PATIENT

Last Name	First Name	MI	Social Security	Birth Date	Sex
Mailing Address			City	State	Zip Code
Home #	Work #			Marital Status	
Email			Ethnicity		
Employer			City	State	Zip Code

RESPONSIBLE PARTY OR POLICY HOLDER (Please indicate which one)

Last Name	First Name	MI	Social Security	Birth Date	Sex
Mailing Address			City	State	Zip Code
Home #	Work #			Marital Status	
Email			Ethnicity		
Employer			City	State	Zip Code

Referring Physician	**Primary Care Physician**

INSURANCE

Primary Insurance	Subscriber's Name	Policy and Group Number
Primary Insurance	Subscriber's Name	Policy and Group Number

Patient Release:

I certify the information that I have provided is correct. I authorize the release of medical information necessary to provide insurance claims to insurance companies of their agencies (including Medicare), for purpose of filing and payment of receive claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR FEE, ATE THE PROVIDE CURRENT RATE, MAY BE CHARGE on all balances owing to the provider that are past due.

Signature:	**Date:**

(Signature of insured or authorized patient or parent of a minor)	

Diabetes Thyroid & Endocrine Advanced Care (DTEAC)

Our Financial Policy

Thank you for choosing us as your endocrine specialist. We are committed to providing you with the best medical care. In order to achieve this goal, we need your assistance and your understanding of our payment policy. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

- All patients must complete our information and insurance from before seeing the doctor.
- Full payment is due at the time of service.
- We accept cash, checks or Visa / Master Card / American Express credit cards.
- Returned checks are subject to a $29.00 service charge.

Healthcare Insurance Plan Obligation:
Diabetes Thyroid & Endocrine maintains a list of the health care services plans. We have agreed to bill those insurances carriers for services rendered. Authorization from your insurance does not always guarantee payment. The person responsible and our patient shall remain responsible for all the charges, applicable copayment and deductibles. If insurance has not responded to our claims submittal within 60 days, payment for services incurred claim status follow up with the insurance carrier becomes the patient responsibility.

Non-participating Insurance:
All fees are due in full at the time of service. A receipt is provided which details all services and pay for the visit. A copy of the receipt can be submitted to your insurance carrier for payment.

PPO/HMO/MEDICARE/Traditional Insurance waiver regarding non-covered patients:
Medicare under section 1862 (A) (1) of the Medicare law and some health insurance plans will only pay 80% of the services that determines to be “Reasonable & Necessary”. If Medicare determines that the particular services is not reasonable and necessary under the Medicare programs standards; or your insurance determines that a service were unauthorized or not covered benefit under your plan, Medicare and other insurance plan will deny payment for these services. We believe that according to your insurance or Medicare plan, payment is often denied for the following services.
Copies of medical record

- Certain labs tests
- Out of network referrals
- Physical
- Pre-existing conditions
- Walk in work in appointments

The undersigned and or patient understands & agrees to be personally and fully responsible for covered services. Our practice is committed to providing the best treatment for our patients. There is a $25.00 fee for missed appointments unless cancelled at least 24 hours in advanced. Please let us serve you better by keeping your appointment. Should collections become necessary, the patient would be responsible for all collection cost and attorneys fee. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read this financial policy. I understand and agree to this financial policy.

Signature:	**Date:**

(Signature of insured or authorized patient or parent of a minor)	

Diabetes Thyroid & Endocrine Advanced Care (DTEAC)

Appointment Cancellation / No Show Policy *(Cancelación de Citas / Póliza de Ausencia Sin Aviso)*

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment cancellation policy. This policy enables us to better utilize available appointments for our patients in severe pain needing immediate care. *(Nuestro objetivo es proporcionar atención médica de calidad en el momento oportuno. Para hacerlo hemos tenido que implementar una póliza de cancelaciones de citas y una póliza de ausentarse sin aviso. Esta póliza nos permite utilizar mejor el tiempo de las citas disponibles para nuestros pacientes que necesitan atención médica.)*

Cancellation of an Appointment *(Cancelación de Citas)*

In order to be respectful of the medical needs of other patients, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call 24 hours in advance. Your early cancellation will give another person the possibility to have access to timely medical care. *(Con el fin de ser respetuosos de las necesidades médicas de otros pacientes, por favor sea cortes y llame a nuestra oficina de inmediato si usted no puede asistir a una cita. Esta podría ser reasignada a otro paciente que esté con necesidad de tratamiento. Si es necesario cancelar su cita, requerimos que usted llame con 24 horas de anticipación. Su cancelación anticipada dará a otra persona la posibilidad de tener acceso a la atención médica oportuna)*

No Show Policy *(Póliza de Ausencia Sin Aviso)*

A "No Show" is someone who misses an appointment without calling 24 hours in advance to cancel. "No Shows" inconvenience those individuals who need access to medical care in a timely manner, as well as the physician. A failure to show up at the time of a scheduled appointment will be recorded in the patients chart as a "No Show". Any "No Show" will result in a fee of $25.00. If a patient accumulates 3 "No Shows", he or she may be asked to leave the practice. *(Un "No Show" es una persona que pierde una cita sin llamar con 24 horas de anticipación para cancelar. "No Shows" incomodan las personas que necesitan tener acceso a la atención medica de manera oportuna, así como al médico. El hecho de no presentarse a la hora de una cita programada será registrado en el historial clínico del paciente como un "No Show". Cualquier "No Shows" resultara en un cargo de $25.00. Si un paciente acumula 3 "No Shows" él o ella se le puede pedir que deje la práctica.)*

Late Cancellations *(Cancelaciones De Última hora)*

Late cancellations will be considered as a "No Show". Exceptions will be made in extraordinary circumstances. Cancellations made more than 24 hours in advance of your scheduled appointment time will not be assessed as a cancellation fee. *(Cancelaciones de última hora serán consideradas como un "No Show". Las excepciones se harán solo en circunstancias extraordinarias. Las cancelaciones realizadas con más de 24 horas antes de su cita, no se les aplicaran un cargo por cancelación.)*

If you have any questions regarding this policy, please let one of our staff know and we will gladly help to clarify any questions you may have. We thank you in advance for your cooperation and understanding. *(Si tiene alguna pregunta sobre esta póliza, por favor, déjele saber a uno de nuestros empleados y estaremos encantados de ayudarle a aclarar cualquier duda que pueda tener al respecto. Le agradecemos de antemano por su cooperación y compresión.)*

I understand this policy and authorize Diabetes Thyroid & Endocrine Advanced Care to assess cancellation and no show fee according to the above outlined policy. *(Entiendo esta póliza y autorizo a Diabetes Thyroid & Endocrine Advanced Care a evaluar la cancelación y "No Show" de acuerdo con la póliza descrita más arriba.)*

Signature:	**Date:**

(Signature of insured or authorized patient or parent of a minor)	

Diabetes Thyroid & Endocrine Advanced Care (DTEAC)

Last Name *(Apellido)*	First Name *(Nombre)*	MI	**Birth Date** *(Fecha Nacimiento)*

Medication List

(Lista de Medicamentos)

Medication Name *(Nombre del Medicamento)*	**Strength/Dosage** *(Dósis)*	**Direction to use** *(Uso)*	**Reason** *(Razón)*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Please list any other medications including over the counter medications

(Por favor anote cualquier otro medicamento, incluyendo medicamentos de venta libre)

Preferred Pharmacy:

Surgical Procedures

(Procedimientos Quirúrgicos)

Surgical Procedure *(Procedimiento Quirúrgico)*	**Date** *(Fecha)*
1.	
2.	
3.	
4.	
5.	

Signature: (Signature of insured or authorized patient or parent of a minor)	Date:

Diabetes Thyroid & Endocrine Advanced Care (DTEAC)

PLEASE INDICATE THE HEALTH HISTORY OF YOUR FAMILY MEMBERS

FAMILY MEMBER (Mother, Father, Sister, Brother, etc.)	GOOD	POOR	DECEASED	CAUSE OF DEATH
1.	O	O	O	
2.	O	O	O	
3.	O	O	O	
4.	O	O	O	
5.	O	O	O	
6.	O	O	O	

PLEASE INDICATE THE HEALTH HISTORY OF YOUR FAMILY MEMBERS

	ME	OTHER		ME	OTHER
HEART DISEASE	O	O	**HIGH BLOOD PRESSURE**	O	O
STROKE	O	O	**CANCER**	O	O
GLAUCOMA	O	O	**DIABETES**	O	O
THYROID DISEASE	O	O	**EPILEPSY/CONVULSIONS**	O	O
BLEEDING DISORDER	O	O	**KIDNEY DISEASE**	O	O
MENTAL ILLNESS	O	O	**OSTEOPOROSIS**	O	O
GOUT	O	O	**HIV/AIDS**	O	O
GI DISORDER	O	O	**HEPATITIS**	O	O
ANEMIA	O	O	**ASTHMA**	O	O
DOUBLE VISION	O	O	**SEXUAL DYSFUNCTION**	O	O
MIGRAINES	O	O	**DEPRESSION**	O	O
GALLSTONES	O	O	**DIZZINESS**	O	O
GOITER	O	O	**LEG PAIN**	O	O
INDIGESTION	O	O	**CONSTIPATION**	O	O
RECTAL BLENDING	O	O	**FAINTING SPELLS**	O	O
FORGETFULLNESS	O	O	**HOARSENESS**	O	O
ABDOMINAL PAIN	O	O	**COLITIS**	O	O

Signature: (Signature of insured or authorized patient or parent of a minor)	**Date:**

Diabetes Thyroid & Endocrine Advanced Care (DTEAC)

ETHNICITY: *(Please chose one)*	**RACE:** *(Please chose one)*
O Hispanic or Latino O Not Hispanic or Latino O Unknown	O American Indian or Alaska Native O Asian O Black or African American O Native Hawaiian or Other Pacific Islander O White O Other

Preferred Language:	**Email:**

ARE YOU ALLERGIC TO ANY MEDICATIONS?

O Yes - Please indicate : _____

O No

PHARMACY INFORMATION FOR ELECTRONIC PRESCRIPTIONS

Pharmacy Name		Phone #
Address	City	State
Do You Have A Mail Order? O Yes O No		
Which One?		Phone #

ARE YOU OR WERE YOU A SMOKER?	**DO YOU DRINK ALCOHOL?**
O Yes - How many packs a day? _____	O Yes
O No	O No

Are you on aspirin or blood thinner (COUMADIN)? O Yes O No

WOMENS

Day of your last menstrual cycle? _____	Cramps?
O Normal O Abnormal	O Yes O No Where:_____

Diabetes Thyroid & Endocrine Advanced Care (DTEAC)

Acknowledgment and Consent for Purpose of Treatment, Payment and Healthcare Operations

In connection with the medical services that I am receiving from Diabetes Thyroid & Endocrine Advanced Care (DTEAC), I hereby authorize the group to disclose any/or all information concerning my medical condition and treatment, including copies of applicable hospital and medical records, to:

a. Any third party payer convering medical services of the patient;
b. Other healthcare professionals and institutions involved in the delivery of health care to the patient;
c. The proponent of any legally sufficient subpoena or in response to a court order;
d. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care sendees and payment for such services;
e. Pharmacies; and
f. Other parties as otherwise required by law.

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further acknowledge that I have received a copy of the practice's privacy notice and had an opportunity to ask questions concerning the Notice of Privacy Practices.

Signature: (Signature of insured or authorized patient or parent of a minor)	**Date:**

Diabetes Thyroid & Endocrine Advanced Care (DTEAC)

Last Name *(Apellido)*	First Name *(Nombre)*	MI

Please check all that apply:

O Fatigue	O Energy Changes
O Changes in sleep	O Unexplained weight gain
O Unexplained weight loss	O Smoking
O Excessive alcohol intake	O Changes in eyes
O Headaches	O Goiter
O Change in goiter	O Neck pressure
O Trouble swallowing	O Palpitations
O Hypertension	O Shortness of breathe
O Anorexia	O Nausea
O Vomiting	O Constipation
O Pancreatitis	O Peptic ulcer disease
O Subtotal or total gastrectomy	O Malabsorption syndromes
O Inflammatory bowel disease	O Cirrhosis
O Low body weight	O Polyuria (excessive urination)
O Polydipsia (excessive thirst)	O Nephrolithiasis
O Renal insufficiency	O Cramps. Where? _____
O Abnormal menstrual cycle. (___) per year.	O Marfan's Syndrome
O Hair Changes	O Decreased Concentration
O Nervousness	O Tremors
O Confusion	O Bone pain
O Muscle weakness	O Rheumatoid arthritis
O Osteopenia / Osteoporosis	O Temperature intolerance
O Previous fracture	O H/O Hyperthyroidism
O H/O Hypogonadism	O Vitamin D deficiency
O H/O Hyperparathyroidism	O Diabetes mellitus
O Growth hormone deficiency	O Multiple myeloma
O Swelling	O Leukemia
O Lymphoma	

Signature: (Signature of insured or authorized patient or parent of a minor)	**Date:**

Diabetes Thyroid & Endocrine Advanced Care (DTEAC)

Disclosure of Medical Information Form (DMI)

(Formulario de Divulgación de la Información Médica)

Last Name *(Apellido)*	First Name *(Nombre)*	MI	**Birth Date** *(Fecha Nacimiento)*

_____ YES – I authorize to release information of my medical status to a family member. *(SI – Autorizo a divulgar información de mi estado de salud a un miembro de la familia).*

_____ NO – I do not authorize to release information of my medical status to a family member or anyone else. *(NO – No autorizo a divulgar información de mi estado de salud a un miembro de la familia o cualquier otra persona).*

Signature: (Signature of insured or authorized patient or parent of a minor)	**Date:**