DIABETES & ENDOCRINE CENTER OF ORLANDO, P.A.

3113 LAWTON ROAD, SUITE 100 – ORLANDO, FL 32803

407-894-3241

WELCOME LETTER

We would like to take this opportunity to welcome you to our practice. Our records indicate that this will be your first office visit with us. If you have been seen in our office (by any physician) under a different name, please notify our staff.

During your first visit you will undergo a brief physical exam and we will review the most recent lab work and/or tests from your primary care or referring physician. It is VERY important that you contact your referring physician to obtain your most recent lab work and last office visit note. If we do not have the medical records from your referring physician, we will not be able to see you and your appointment will have to be rescheduled. We encourage our patients to call us 3 days prior to your new patient appointment to ensure that we have received the medical records.

We require payment for professional services and/or co-payments at the time services are rendered. Please review our Financial Policy for complete information.

You need to bring the following with you to your appointment:

1) Completed new patient paperwork
2) Insurance Referral/Authorization
3) List of medications or your medication bottles
4) Photo I.D.
5) Insurance Card
6) **Medical records pertaining to the condition that you are coming to see us for (MRI, CT, Labs, Office notes).**

We ask that you arrive 20 minutes early for your appointment to allow us to get you registered in our computer system. Please note, if you arrive greater than 15 minutes past your scheduled appointment time you may have to wait or possibly be rescheduled. If you find it necessary to cancel or reschedule your appointment, please do so at least 24 hours in advance to prevent being charged a **NO SHOW FEE OF $100.00**. This notice will also enable us to give other patients, who need to be seen, an earlier appointment.

We look forward to seeing you and having you as our patient here at Diabetes & Endocrine Center of Orlando, P.A.

Sincerely,

The team at Diabetes & Endocrine Center of Orlando, P.A.

DIABETES & ENDOCRINE CENTER OF ORLANDO, PA
3113 LAWTON ROAD, SUITE 100 - ORLANDO, FL 32803
(407) 894-3241

PERSONAL INFORMATION

First Name	Middle Name	Last Name	Preferred Name
Birthdate	Sex	Marital Status	Social Security Number (*required for insurance purposes*)
Race ☐ Asian ☐ African American ☐ Caucasian ☐ Chinese ☐ East Indian ☐Filipino ☐ Hispanic ☐ Japanese ☐Native American ☐ Other			Primary Language:
Street Address			
City	State	Zip	County
Mailing Address			
City	State	Zip	County
Home Phone	Work Phone		
Cell Phone	E-Mail Address		

HIPAA COMPLIANCE

What phone numbers may we call to discuss your medical care?	☐ **Home**	☐ **Cell**	☐ **Work**
Where may we leave a message on your answering machine or voice mail?	☐ **Home**	☐ **Cell**	☐ **Work**

PRIMARY CARE PHYSICIAN

Primary Care Physician		
Phone #	Fax #	
Address	City	Zip

IF YOU WERE REFERRED TO US, PLEASE LET US KNOW WHO REFERRED YOU?

☐ Primary Care Physician ☐ Hospital/ER ☐ Nurse/Hospital/Physician Staff ☐ Friend/Relative ☐Yellow Pages ☐ Other
Name:
Phone # (if a doctor)

PATIENT'S EMPLOYMENT INFORMATION

Employer	Occupation	
Street Address		Phone#
City	State	Zip

SPOUSE INFORMATION

Name	Date of Birth
Cell Phone	Work Phone
May we discuss your medical care with your spouse? ☐ **Yes** ☐ **No**	

Who can we discuss your medical care with other than your spouse?

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

Emergency Contact- Person not living with patient (relative or friend)

Name	Relationship	Phone

PATIENT NAME _____

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HEALTH INSURANCE INFORMATION

Primary Insurance Company	
ID#	
Policy Group #	Group Name
Subscriber's Name	
Subscriber's Birth date	Relationship to Patient
Subscriber's Social Security # *(required for insurance purposes)*	

Secondary Insurance Company	
ID#	
Policy Group #	Group Name
Subscriber's Name	
Subscriber's Birth date	Relationship to Patient
Subscriber's Social Security # *(required for insurance purposes)*	
If Medicare is secondary please specify the reason why:	

PHARMACY INFORMATION

Local Pharmacy	Phone #
Address	Fax#

Mail Order Pharmacy (example Medco or Express Scripts)	Phone #
	Fax#

Pharmacy for Diabetic Supplies (test strips and lancets)	Phone #
	Fax#

OTHER SPECIALISTS THAT YOU CURRENTLY SEE

SPECIALTY	NAME	PHONE #
CARDIOLOGY		
HEMATOLOGY/ONCOLOGY		
NEUROLOGY		
NEPHROLOGY		
OB/GYN		
OPTHALMOLOGY		
PODIATRY		
PSYCHIATRY		
SURGEON		

Signature:_____ Date:_____
(Patient and/or Responsible Party)

DIABETES & ENDOCRINE CENTER OF ORLANDO, P.A.

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407-894-3241

FINANCIAL POLICY

Welcome to our practice. We are committed to providing you with the best possible care and are open to discussing our professional fees and policies with you at any time.

It is imperative that a current copy of your **insurance card and valid photo ID** is provided for accurate billing. Please bring your insurance card and photo ID with you to each visit. If you do not provide correct insurance information to the office, this may result in claims being denied for timely filing. If a claim is denied for timely filing, you may be responsible for all charges. In addition, it is extremely important for you to educate yourself about your individual insurance benefits. If you are unsure of your coverage benefits, call the customer service number on your insurance card.

Insurance is a contract between you and your insurance company. We cannot become involved in disagreements between you and the insurance company regarding deductibles, co-payments, covered charges, etc. It is your responsibility to know if your insurance has a "participating provider list" and to verify if the doctors you see are on that list and understand how that affects your benefits. It is your responsibility to obtain required referrals and/or prior authorizations from your primary care physician (PCP) and to track the effective dates and number of visits authorized. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover, or which they may consider medically unnecessary. In some instances you will be responsible for these amounts. We will make every effort to ascertain your coverage of our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier.

If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the plan for all charges for services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of:

Annual deductibles Co-payments/Co-insurance Charges for non-covered services

In the event we are not aware of a charge that is not covered by your plan, you will be billed after we obtain a denial from your insurance.

We are Medicare participating providers. We will bill Medicare and most secondary carriers (we do not participate with Medicaid). You will be responsible at the time of service for payment of :

Annual deductibles Co-insurance (no secondary insurance) Charges for non-covered services

If you have Medicare as well as secondary coverage, we will file a claim to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental plan within 60 days after we file a claim, you will be sent a bill and will be responsible for the remaining account balance.

Our goal is to provide quality medical care to all of our patients. We do not discriminate against patients that do not have medical insurance; however, we do feel that it is important for uninsured patients to be aware of the following:

Self-pay patients must pay entire discounted amount at the time of service. An endocrine evaluation is specialized and generally requires additional diagnostic testing with either laboratory blood tests (that can run several hundred dollars

or x-rays/scans that can run into thousands of dollars). The fees for these tests are above and beyond the physicians charges. We do not have control over the cost of diagnostic testing and these services will be billed by the provider of service. Please understand that any tests ordered are required for us to evaluate and treat your medical condition. If you will not be able to comply with the testing, we will not be able to provide you with the level of care that an endocrinologist is expected to provide. In addition to diagnostic testing, prescription medications may be required and again we do not control the cost of the medications. The above information has been provided to avoid causing undue stress to any patient due to a financial burden that was not anticipated. We will provide the same quality care to all patients and believe that the financial and time burden is unfair, to both the patient and our practice, if the patient presents for the initial visit and then abandons care because they cannot proceed with the necessary diagnostic testing or prescription medications. Patients with past due balances must pay the entire past due balance, plus current days charges, prior to being seen. **If you are not able to pay at the time of check-in, we will need to reschedule your visit; and this visit will be considered a "no show".**

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. **Cancellations are requested 24 hours prior** to the appointment. There will be a **$25** charge for missed or late canceled appointments. Excessive abuse of the scheduled appointments will result in discharge from the practice. All accounts with patient balances that are not paid within 59 days will have a $10 statement fee added for each monthly statement that we mail.

Payments may be made with cash, personal check, Visa, MasterCard, or Discover. There is a $25 service charge for returned checks and if this occurs personal checks will no longer be accepted.

Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions.

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Credit Card Authorization **OPTION**

The information below may be added as a payment option (**not mandatory**).

My signature below allows this office to charge any outstanding balance to my credit card not to exceed $_____.

_____ ( )Visa ( ) MasterCard ( ) Discover

Name on card (PRINT)

_____

Card # Expiration Date

_____

Authorized Signature

I have read and understand the Diabetes and Endocrine Center of Orlando, P.A. Financial Policy. I agree to assign insurance benefits to Diabetes and Endocrine Center of Orlando, P.A. whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

_____

Print Patient Name Patient Signature Date

Diabetes & Endocrine Center of Orlando, P.A.
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes 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 which may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office at 407-894-3241 and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. **Uses and Disclosures of Protected Health Information**

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent
You will be asked by your physician to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your physician will use and disclose your protected health information described in **Section 1**. Your protected health information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that the physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office, once you have provided consent.

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 and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, 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. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

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, marketing and fundraising activities, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical school students that see patients at 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 provider. We may also call you by name in the waiting room when your provider 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 will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing purposes. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. 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.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician, may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to a person' involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practical after the delivery of your treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclose under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required by Law: We may use or disclose your protected health information to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health/Communicable Diseases: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other governmental regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health agency authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that a death as occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order for the funeral director to carry out their duties. We may disclose such information in a reasonable anticipation of death.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or to the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility benefits, or (3) to foreign military authority if you are a member of a that foreign military services.

Worker's Compensation: Your protected health information may be disclosed by us as authorized to comply with Workers' Compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

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 et. seq.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of your protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. Your physician is not required to agree to a restriction that you may request. If a 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. If your physician does agree to your requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to receive confidential communications from us.

You may have the right to have your physician amend your protected health information. This means that you may request an amendment of protected health information about you in a designated record set for as long as we maintain the information. In certain cases, we may deny your request for an amendment. If we deny your request for an 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. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

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 electronically.

3. Complaints

You may complain to Diabetes & Endocrine Center of Orlando, P.A. or to the Secretary of Health and Human Services if you believe your privacy has been violated. We will not retaliate against you for filing a complaint. Your complaint must be submitted in writing no later than 180 days from the perception of a violation related to your protected health information.

To file a complaint to the Secretary of the Department of Health and Human Services, use the following address:

Office of the Secretary, US Department of Health and Human Services
200 Independence Avenue SW, Washington, DC 20201

To contact the Region IV Office of the Health and Human Services Office of Civil Rights, call: 404-562-7886.

You may contact our Privacy Officer, Debbie Howard, at 407-894-3241 to discuss any perceived violation of your protected health information.

This notice was published and becomes effective on November 13, 2007.

DIABETES & ENDOCRINE CENTER OF ORLANDO, P.A.

3113 LAWTON ROAD, SUITE 100 – ORLANDO, FL 32803

407-894-3241

PATIENT: _____ DOB: _____

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to evaluation or treatment the assigned healthcare provider may deem necessary to the patient named above.

_____ _____

PATIENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE DATE

INSURANCE ASSIGNMENT

I hereby authorize my insurance benefits to be paid directly to Diabetes & Endocrine Center of Orlando, PA. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

_____ _____

PATIENT SIGNATURE DATE

ADVANCE DIRECTIVE

I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my care givers to the extent permitted by law. Please check one of the following statements:

( ) I HAVE executed an Advance Directive. (Living Will, Durable Power of Attorney, Desig. of a Health Care Surrogate)
Please provide copies of Advance Directive/Living Will to the receptionist to be included in your medical record.

( ) I HAVE NOT executed an Advance Directive. (Living Will, Durable Power of Attorney, Desig. of a Health Care Surrogate)

_____ _____

PATIENT SIGNATURE: DATE

FOR MEDICARE PATIENTS ONLY – MEDICARE PART B SIGNATURE AUTHORIZATION – LIFETIME

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

_____ _____

PATIENT NAME PATIENT SIGNATURE

_____ _____

MEDICARE HIN# DATE

DIABETES & ENDOCRINE CENTER OF ORLANDO, PA

3113 LAWTON ROAD, SUITE 100 - ORLANDO, FL 32803

PH: (407) 894-3241

FAX: (407) 896-9863

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (MEDICAL RECORD)

PLEASE COMPLETE ALL FIELDS

SECTION A: Must be completed for ALL Authorizations

By signing this Authorization, I hereby authorize and permit the use and/or disclosure of my protected health information (medical record) for the limited purpose(s), and in the limited manner, described in this form. In addition, I understand that this Authorization is completely voluntary and I am signing it under my own free will.

Patient Name: _____ Patient #_____

Home Address: _____ Date of Birth: _____

Persons/organizations providing the information: (Complete w/Address)

Persons/organizations receiving this information: (Complete w/Address)

Specific description of information (including date(s)) to be used and/or disclosed about me:

*** The following items must be initialed to be included in the use or disclosure of other health information:**

- ☐ * HIV / AIDS related health information and/or records.
- ☐ * Mental health information and/or records.
- ☐ * Genetic testing information and/or records.
- ☐ * Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the disclosure of such information.)

SECTION B: MUST BE COMPLETED ONLY IF DIABETES & ENDOCRINE CENTER OF ORLANDO, PA HAS REQUESTED THE AUTHORIZATION

1. DECO must complete the following:
   a. What is the purpose of the use or disclosure? (Check one.)
      - ☐ At the patient's (or the patient's representative's) request or direction.
      - ☐ For marketing.
      - ☐ For fundraising.
      - ☐ Other (describe):

2. The patient or the patient's representative must read and initial the following statements:

   a. I understand that my health care and the payment for my health care will NOT be affected if I DO NOT sign this form. Initial: _____

   b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Initial: _____

SECTION C : Must be completed for ALL Authorizations

The patient or the patient's representative must read and Initial the following statements:

I understand that this Authorization will expire. (Please choose 1 of the 3 options listed below):

a. No expiration (permitted only for Authorizations used to create or maintain research databases or repositories). Initial: _____

b. On _____ (DD/MM/YYYY) Initial: _____
   Date

c. When the following event occurs [ ] Initial: _____

_____ _____
Signature of Patient or Patient's Representative Date
(Form MUST be completed before signing)

Print Name of Patient's Representative: _____

Relationship to the Patient: _____

Reason Authorization is signed by the Patient's Representative: (Check one)

- ☐ Minor
- ☐ Incompetent
- ☐ Other (Explain) _____

*** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**

*If this Authorization form authorizes use and/or disclosure of psychotherapy notes, it may not be used to authorize the use and/or disclosure of any other protected health information. A separate Authorization form is needed for any other use and/or disclosure.

diabetes and endocrine
center of orlando, p.a.

Patient Medical History

Patient's Name: _____ **Date:** _____ **Chart#:** _____

Social History

Marital Status: Single___ Married___ Divorced___ Widowed___

Occupation: _____

Exercise Habits: Sedentary___ Modestly Active___ Very Active___

Current Smoker: Yes___ No___ Previous Smoker: Yes___ No___
If yes: #of packs___ # of years___

Alcohol: Never___ Rare___ Weekly___ Daily___ Currently Using___

Illicit Drug Use: None___ Prior Problem___

How much (in time shown above) _____

	Y	N
Constitutional		
Chills		
Fatigue		
Fever		
Night Sweats		
Weight Loss		
Eyes		
Difficulty seeing		
Double vision		
Eye pain		
Glasses/Contacts		
Ear/Nose/Throat		
Difficulty hearing		
Dizziness		
Frequent nose bleeds		
Frequent sore throat		
Hoarseness		
Nasal stuffiness		
Ringing in ears		
Sinus trouble		
Tooth or gum problems		
Cardiovascular		
Chest pain		
Difficulty lying flat		
Fainting spells		
Irregular heartbeat		
Leg pain while walking		
Murmur		
Palpitations		
Short of breath		
Swollen ankles		
Respiratory		
Cough		
Coughing blood		
Wheezing		

	Y	N
Gastrointestinal		
Abdominal pain		
Black/tarry stool		
Changes in appetite		
Changes in bowel habits		
Constipation		
Diarrhea		
Difficulty swallowing		
Heartburn		
Incontinence of stool		
Jaundice		
Persistant nausea/vomit		
Rectal bleeding		
Severe indigestion		
Genitourinary		
Abnormal urine discharge		
Blood in urine		
Burning urination		
Difficulty urinating		
Excessive urination night		
Frequent urination		
Frequent urine infections		
Pain on urination		
Sugar/protein in urine		
Urine incontinence		
Female Only		
Irregular periods	_____	
Age onset periods	_____	
Age menopause	_____	
Last period ended	_____	
Hematological/Lymphatic		
Enlarged lymph glands		
Prolonged bleeding		
Easy bruising		

	Y	N
Musculoskeletal		
Back pain		
Joint pain/swelling		
Muscle pain		
Stiffness		
Skin		
Change in hair or skin		
Itching or burning of skin		
Other skin lesions		
Rashes or sores		
Neurologic		
Difficulty speaking		
Memory loss		
Numbness		
Severe frequent headaches		
Tremors		
Severe weakness/paralysis		
Endocrine		
Changes in nails		
Decreased sex drive		
Excessive thirst		
Hay/cold intolerance		
Loss of hair		
Males Only		
Problem with erections		
Allergic/Immunologic		
Hay fever symptoms		
Hives		
Psychiatric		
Anxiety/depression		
Attempted suicide		
Hallucinations		
Insomnia		
Mood swings		
Other symptoms:		

Medication Allergies:

Reviewed by: _____ **Date:** _____

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Initial Visit Medical History

Patient's Name: _____ **Date:** _____

Past Medical History: Please check each item in the area indicated **"YES"** or **"NO"** as it relates to your personal past medical history.

	Y	N		Y	N		Y	N
Alcoholism	☐	☐	Glaucoma	☐	☐	Phlebitis	☐	☐
Anemia	☐	☐	Gout	☐	☐	Pneumonia	☐	☐
Arthritis	☐	☐	Heart Attack	☐	☐	Prostate Disease	☐	☐
Asthma - Hay Fever	☐	☐	Heart Disease	☐	☐	Psoriasis - Eczema	☐	☐
Bleeding Disorder	☐	☐	Hemorrhoids	☐	☐	Rheumatic Fever	☐	☐
Cancer	☐	☐	Hepatitis	☐	☐	Seizures	☐	☐
Cataracts	☐	☐	Hernia	☐	☐	Epiliepsy	☐	☐
Chronic Bronchitis	☐	☐	High Blood Pressure	☐	☐	Sinusitis	☐	☐
Colitis (bowel inflammation)	☐	☐	High Cholesterol	☐	☐	Stroke	☐	☐
Crohn's Disease	☐	☐	Kidney Infections/Stones	☐	☐	Thyroid Disease	☐	☐
Depression	☐	☐	Other Kidney Disease	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Mental Illness	☐	☐	Ulcerative Colitis	☐	☐
Diverticulosis	☐	☐	Migraine Headaches	☐	☐	Varicose Veins	☐	☐
Emphysema	☐	☐	Nervous Breakdown	☐	☐	Venereal Disease	☐	☐
Gall Bladder Disease	☐	☐	Osteoporosis	☐	☐	Worms	☐	☐
			Peptic Ulcers	☐	☐	Parasites	☐	☐

Please list all past surgeries together with the estimated date of their occurrence.

Surgery:	Est. Date

Please list all previous nonsurgical hospitalization(s) together with the estimated dates of their occurrence.

Hospitalization:	Est. Date

Family Medical History: Please check each item in the box indicated **"YES"** or **"NO"** as it relates your family's medical history.

	Y	N		Y	N		Y	N
Anemia	☐	☐	Emphysema	☐	☐	Migraine Headaches	☐	☐
Arthritis	☐	☐	Glaucoma	☐	☐	Osteoporosis	☐	☐
Asthma	☐	☐	Heart Attack	☐	☐	Seizures - Epilepsy	☐	☐
Bleeding Disorder	☐	☐	Other Heart Disease	☐	☐	Stomach Ulcers	☐	☐
Cancer	☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐
Depression	☐	☐	Kidney Disease	☐	☐	Thyroid Disease	☐	☐
Diabetes	☐	☐	Mental Illness	☐	☐	Tuberculosis	☐	☐

Relative	If Living		If Deceased		Relative	If Living		If Deceased	
	Age	Health	Age of Death	Cause of Death		Age	Health	Age of Death	Cause of Death
Father					Children				
Mother									
Brother & Sisters									

Reviewed by: _____ **Date:** _____

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MEDICATION LIST – PLEASE PRINT CLEARLY

Patient Name	Date

DRUG ALLERGIES:

Medication	**Dosage -** **mg, units, etc**	**Instructions –** **1 a day, 1 twice a day**	**Prescriber**