Sohail H. Ali, M.D.
Julie A. Bauer, M.D.

# Endocrine & Diabetes Consultants of Central Florida, LLC

635 N. Maitland Ave.
Maitland, FL 32751

**Tel: (407) 436-9601** • Fax: (407) 833-6797
**www.EDCCF.org**

## WELCOME TO OUR OFFICE

The physicians and staff at Endocrine and Diabetes Consultants of Central Florida strive to provide our patients with the best health care and personalized service possible. Enclosed in this packet is information concerning our office's policies and forms that you need to fill out and mail back to our Maitland office as soon as possible. This will enable our staff to ensure that your visit will flow more efficiently.

Your appointment is scheduled for:

Date: _____ Time: _____ Physician _____

## NEW PATIENT PROCESS

1. **Please complete all the enclosed forms and return to us as soon as possible.**
   - **Patient Information Form**
   - **Authorization Form**
   - **Patient Consent**
   - **Initial Endocrine/Diabetes Medical History**
   - **Medication List**
   - **Bubble Sheet ( Please fill in the appropriate circle with an ink pen)**
   - **A written order from your primary physician requesting an endocrinology opinion if you have been referred by another physician**
   - **A referral from your physician if required by an HMO policy**
   - **Recent copies of your lab results, medical records and imaging studies.**
2. When you check in you will need a photo I.D., your insurance card and your co-payment.
3. **The registration time for a new patient is 30 minutes prior to your appointment and 15 minutes for an established patient.**
4. Our 24/7 cancellation number is: **407-436-9601**

## OTHER HELPFUL INFORMATION

1. If you arrive late for your appointment, we will check the doctor's schedule and make every effort to see you, but your appointment may have to be rescheduled.
2. Missed follow up appointments will be charged $25 for established patient and $50 for new patients. Arriving late for your appointment will be deemed as a missed appointment.

   In endocrine diseases it is extremely important to take the medications consistently and the appropriate doses. It is our belief that this can best be acheved if medications are filled at the time of the office visit after discusssing with your provider. For your office visit, please bring a list of medications (prescribed by us) that you need refilled. We will not entertain any refill requests from pharmacies. If you require any refills between visits, you will be $10.00 per prescription.

3. You may use the patient portal to check your appointment date and times.

4. We encourage you to communicate through the patient portal .

5. Once you have selected your physician, **we do not switch physicians within the practice**

6. Unless otherwise stated Lab test results will be available thru the patient portal after your follow up appointment.

**Important Note:** If you have diabetes and have a fasting lab, please bring your insulin, syringe and a snack to have after your appointment.

**FINANCIAL POLICY**

1. Payment is required the day of your office visit. We accept cash, checks and all major credit cards. We bill your insurance solely as a courtesy to you for any additional amount due. If you are unable to pay your co-payment / balance, your appointment will be rescheduled.
2. **Co-payments and account balances are collected at the check-in window prior to your visit**.
3. If your insurance carrier does not remit payment within 30 days, the balance will be due in full from you.
4. Some insurance carriers (GHI and BS of Puerto Rico) send the check owed to the doctor directly to the patient. If you have a secondary insurance that does not pay the doctor directly, the 20% coinsurance is due at time of check out.
5. We don't file secondary insurance, unless supplement to Medicare or Medicare is the secondary payer.
6. Self-pay patients are required to pay in full at time of services.
7. If your secondary insurance is Medicaid, because we are not participating, you are responsible for your deductible and the 20% coinsurance that Medicare does not cover. This amount is due at check out.
8. Our return check fee is $50.00

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| LAST NAME | FIRST NAME | M.I. | TODAY'S DATE |
|---|---|---|---|
| | | | |

| STREET ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

| SEX ❒ Male ❒ Female ❒ Transgender male ❒ Transgender female ❒ Non-binary | PHONE ( ) | CELL PHONE ( ) | EMAIL ADDRESS | AGE | D.O.B. |
|---|---|---|---|---|---|
| | | | | | |

RACE ❒ AMERICAN INDIAN/ ALASKA NATIVE ❒ ASIAN ❒ WHITE ❒ BLACK / AFRICAN AMERICAN ❒ HAWAIIAN ❒ HISPANIC ❒ OTHER _____

MARITAL STATUS ❒ S ❒ M ❒ W

| ETHNICITY ❒ HISPANIC ❒ NON HISPANIC | DRIVER'S LICENSE NO. | STUDENT STATUS ❒ FULLTIME ❒ PARTTIME ❒ NOT ATTENDING |
|---|---|---|
| | | |

| SOCIAL SECURITY NO | EMPLOYMENT STATUS ❒ FULL TIME ❒ PART TIME ❒ NOT EMPLOYED ❒ SELF EMPLOYED | OCCUPATION |
|---|---|---|
| | | |

| EMPLOYER'S NAME | STREET ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|---|
| | | | | |

HOW DID YOU HEAR ABOUT US? ❒ FAMILY/FRIEND ❒ PHYSICIAN ❒ INSURANCE ❒ INTERNET

EMPLOYER'S PHONE ( )

| REFERRED BY | FAMILY PHYSICIAN |
|---|---|
| | |

## INSURANCE INFORMATION

| INSURANCE COMPANY | PHONE ( ) |
|---|---|
| | |

ADDRESS

CITY/STATE/ZIP

| POLICY / ID NUMBER | GROUP # |
|---|---|
| | |

| INSURED'S LAST NAME | FIRST NAME | D.O.B. |
|---|---|---|
| | | |

RELATIONSHIP TO INSURED ❒ SELF ❒ HUSBAND ❒ PARENT ❒ WIFE ❒ OTHER

EMPLOYER'S. INSURANCE PLAN ❒ YES ❒ NO

## SECONDARY CARRIER

| INSURANCE COMPANY | PHONE ( ) |
|---|---|
| | |

ADDRESS

CITY/STATE/ZIP

| POLICY / ID NUMBER | GROUP # |
|---|---|
| | |

| INSURED'S LAST NAME | FIRST NAME | D.O.B. |
|---|---|---|
| | | |

RELATIONSHIP TO INSURED ❒ SELF ❒ HUSBAND ❒ PARENT ❒ WIFE ❒ OTHER

EMPLOYER'S. INSURANCE PLAN ❒ YES ❒ NO

**IN CASE OF EMERGENCY, WHO SHOULD WE CALL?**

| NAME | RELATION | PHONE ( ) | WORK PHONE ( ) |
|---|---|---|---|
| | | | |

| STREET ADDRESS | CITY/STATE/ZIP |
|---|---|
| | |

PATIENT SIGNATURE: X_____ DATE:_____

LEGAL GUARDIAN SIGNATURE:_____ DATE:_____

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## AUTHORIZATION

PATIENT: _____

**1. CONSENT FOR TREATMENT:**

The patient and/or authorized representative of the patient, whose signature is affixed below, does hereby consent to any medical treatment which may be deemed advisable by my physician. The intention, hereof being to grant authority to administer and perform all singular exams, treatment and diagnostic procedures which may now or during the course of my care be deemed necessary. These services may include telehealth or other virtual or electronic services. The physician may forward electronic communications to other staff involved in the delivery and administration of your care. These services may result in additional charges being filed with your insurance based on the terms and conditions of our payer contract. These charges may include the actual time spent working on specific tasks related to patient care and or treatment planning in between your office visits.

_____ _____

Signature of Patient Date

**2.** We welcome you to our specialty practice of endocrinology. In our effort to provide quality health care, it is important to maintain a consistent patient-physician working relationship. For this reason, as endocrine physicians, we expect that all our patients be diligent in keeping all of their scheduled appointments. Endocrine problems require on going care and failure to do so may result in complications which can be irreversible. Continuity of care is essential in the successful management of endocrine diseases. Therefore, failure to maintain this relationship by missing scheduled follow up appointments will result in discharge from this practice.

I have read and understand my obligation to maintain the quality of my healthcare and understand that if I consistently miss scheduled follow up appointments recommended by my endocrinologist that the consequence will result in discharge from Endocrine and Diabetes Consultants of Central Florida, LLC.

_____ _____

Signature of Patient Date

**3. ASSIGNMENT OF INSURANCE AND MEDICARE BENEFITS:**

I hereby authorize payment directly to Endocrine and Diabetes Consultants of Central Florida , LLC of benefits otherwise payable to me for medical services incurred. In making this assignment to the physician, I understand and agree that any unpaid balances not covered by this policy will be payable by me. If payment is not received from my insurance company within 30 days of the date of my treatment, I am aware that I am fully responsible for the entire balance in full.

_____ _____

Signature of Patient Date

**4. SELF PAYMENT AGREEMENT:**

I have agreed to accept full responsibility for payment for any charges incurred to Endocrine & Diabetes Consultants of Central Florida, LLC. and have agreed to pay for these services in full at time of service.

_____ _____

Signature of Patient Date

**5. POS/PARTICIPATING HMO PATIENTS:**

It is the responsibility of the patient to obtain prior authorization from your primary care physician before each visit to our office. I understand that if this is not done. I will be responsible for any unpaid balance due.

_____ (Please initial that you have read and understand.)

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# PATIENT CONSENT

## FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In connection with the medical services I am receiving from Endocrine and Diabetes Consultants of Central Florida, LLC. I consent to and authorize the above -named physicians and group to use and disclose any and all **P**rotected **H**ealth **I**nformation (**PHI**) necessary to carry out treatment, payment, and health care operations (**TPO**) related to my medical care, unless noted below, medical records may include results or tests for HIV antibody, substance abuse or treatment in regard to either of the aforementioned .

I have read and understand the Notice of Privacy Practices that offer a more complete description of such uses and disclosures. Copies are available in the waiting room and exam room. This office reserves the right to review and change their Notice of Privacy Practice any time.

Endocrine and Diabetes Consultants of Central Florida , LLC. may call my home or office and leave a message in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and call pertaining to my health care.

Endocrine and Diabetes Consultants of Central Florida , LLC. may mail to my home or office any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statement.

I have the right to request that this practice restrict how they use or disclose my protected health information (PHI) to carry out treatment, payment and health care operations (TPO). However, this office is not required to agree to my requested restrictions, but if they do, the office is bound by this agreement.

By signing this form, I consent to the use and disclosure of my PHI to carry out treatment, payment and health care operations (TPO). This consent may be revoked by submitting a request in writing. If I decline to sign this consent, this practice may decline to provide treatment.

Printed Patient Name: _____

Signature of Patient: _____

Signature of Legal Guardian: _____

Date: _____

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## INITIAL ENDOCRINE / DIABETES MEDICAL HISTORY

**Name** _____ **Date:** _____ **DOB:** _____

**Reason For Visit / Diagnosis** _____ **Referral Physician:** _____

**Medical History:** ( please check all that apply)

❒ Thyroid ❒ Diabetes ❒ High blood pressure
❒ Pneumonia ❒ Heart attack ❒ Ulcer ❒ Kidney ❒ Liver
❒ Pituitary ❒ Cancer ❒ High Cholesterol ❒ Gout ❒ Neuropathy

**Additional Medical History:** _____

**Surgical History:** _____

**Family History:** ( please check all that apply) ❒ Diabetes ❒ Thyroid ❒ Kidney Stones ❒ Heart
❒ Gout ❒ Cancer ❒ Hypertension ❒ Others? _____

**Social History:** Single Married Divorced

Occupation: _____ Children? How many? _____

Do you smoke? ❒ Yes ❒ No If yes, how many times daily? _____
Do you consume alcohol daily? ❒ Yes ❒ No If yes, how much? _____
Do you exercise? ❒ Yes ❒ No If yes, how many times weekly? _____
Do you use caffeine? ❒ Yes ❒ No If yes, how much daily? _____
**Do you have any allergies?** ❒ Yes ❒ No If yes, please list. _____

### DIABETES PATIENTS ONLY

1. When were you diagnosed with diabetes? _____
2. Have you ever been hospitalized for high blood sugars or DKA ? ❒ Yes ❒ No _____
3. Do you have frequent low blood sugar reactions? ❒ Yes ❒ No _____

How often? _____ What time day or night? _____

4. Do you test your own blood sugar? ❒ Yes ❒ No What meter? _____

How often? _____ What is your blood sugar range ? _____

5. Have you had diabetes education ? ❒ Yes ❒ No

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## CONSENT TO DISCLOSE MEDICAL INFORMATION

Name: _____ D.O.B. _____

Please check one of the following:

☐ I give permission to the employees of Endocrine & Diabetes Consultants of Central Florida, LLC to disclose my Protected Health Information to me and the following individual (s).

Name: _____ Relation _____

Name: _____ Relation _____

Name: _____ Relation _____

Name: _____ Relation _____

Name: _____ Relation _____

Name: _____ Relation _____

☐ I request that all my Protected Health Information be disclosed ONLY to me and no other individual(s).

I understand that I may revoke or change this consent at any time by filling out another consent form to replace this one. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent to disclose medical information shall be valid for a period of one calendar year unless otherwise expressly stated.

_____ _____

Patient Name (Print) Date

_____

Patient or Guarantor (Signature)

## ENDOCRINE & DIABETES CONSULTANTS OF CENTRAL FLORIDA, LLC

## NEW PATIENT MEDICATION LIST

Name: _____ Date of Birth _____

| Medications: Include all Prescriptions, Vitamins Supplements, Over the counter medications, Injectable and Insulin. | Strength | # times / day |
|---|---|---|
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Drug Allergies: _____

_____

_____

_____

Name of Preferred Pharmacy