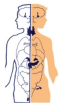
ENDOCRINE ASSOCIATES OF FLORIDA, P.A.



CONTRACT FOR CARE

BETWEEN ENDOCRINE ASSOCIATES OF FLORIDA (E.A.F) AND OUR PATIENTS

PATIENT NAME (PLEASE PRINT): _____

The physicians and staff of E.A.F. are pleased that you have chosen us to provide necessary medical care in the specialty of Endocrinology. To help clarify our professional relationship, we want to review important issues and expectations:

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 my be deemed advisable by the provider. 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.

_____ _____

Signature of patient/representative Date

2. ENDOCRINOLOGY SPECIALTY PRACTICE

As consultants in endocrinology, diabetes and metabolism, our role is to provide guidance to you and your primary care physician (PCP). We do not serve in the capacity of a PCP or internist and will not prescribe medications outside of our specialty. Should you require the name of a PCP, we will be happy to recommend one to you.

Many of our patients have chronic conditions that require life-long supervision. The providers will do their best to help you, but we need your cooperation in managing your condition. Once stable, the physician may refer you back to your PCP without the need for a follow-up with us. Should circumstances change, we will be happy to see you again upon referral from your PCP.

_____ _____

Signature of patient/representative Date

3. INSURANCE POLICY

An insurance contract is between you and your insurance company. It is the patient's responsibility to understand the terms and benefits of the contract. If you are unsure of these benefits, contact your insurance carrier prior to your visit. Please note we do not participate with every insurance plan and encourage patients to verify their benefits before being seen. We will file claims to a secondary insurance as a courtesy, any unpaid balance is the patient's responsibility.

_____ _____

Signature of patient/representative Date

4. ASSIGNMENT OF INSURANCE AND MEDICARE BENEFITS

I hereby authorize payment directly to Endocrine Associates of Florida, P.A. of benefits otherwise payable to me for medical services incurred. In making this assignment to the practice, I understand and agree that any unpaid balances not covered by my policy will be payable by me. If payment is not received for 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/representative

Date

5. MEDICARE/MEDICAID POLICY

We accept assignment on all Medicare claims. We will also file Medicare Supplement claims. If you switch to a Medicare Advantage or replacement plan, it is your responsibility to inform the office prior to your next visit. We accept Medicaid plans as a secondary only.

Signature of patient/representative

Date

6. REFERRAL/AUTHORIZATION POLICY

For those patients that require a referral in order to be seen, it is the patient's responsibility to inform the practice. We will send referral requests to your primary care physician prior to your appointment as a courtesy, but if we do not receive the proper documentation 24 hours before your scheduled visit, we will reschedule your appointment.

Signature of patient/representative

Date

7. SELF PAY PATIENTS

We do accept self-pay patients for those who qualify. Patients not covered by any insurance plans or covered by policies that we are unable to bill directly should expect to pay for services billed at our standard rates. The following rates are guidelines only and are subject to change at any time.

- **New Patients:** $250 for initial consultation
- **Established patients:** $85-$100 for each follow up visit
- **Additional services:** including diagnostic testing and labs, are not included in the estimates above are rendered at an additional fee

Signature of patient/representative

Date

8. FINANCIAL POLICY

Payment of any co-payment, deductible, coinsurance and account balance will be collected at check-in prior to your visit. We accept cash, Visa, MasterCard, American Express and Discover cards. We DO NOT accept checks as payment in the office. If you are unable to pay your co-payment or balance upon arrival, your appointment will be rescheduled.

Signature of patient/representative

Date

9. ATTENDANCE POLICY

In an effort to provide you with exceptional care, it is *important to maintain a consistent patient-physician working relationship*. Continuity of care is essential in the successful management of endocrine disorders. We therefore expect that all patients be diligent in keeping their scheduled appointments.

Failure to maintain this relationship by consistently missing scheduled appointments will result in fees and/or dismissal from the practice. Patients that show more than 15 minutes late to their appointment will be asked to reschedule.

- **New patients** are allowed one non-emergent reschedule. Rescheduling at any time will result in a **$50 fee**.
- **Established patients** must give 48 business hours notice from the time of their appointment to reschedule. Failure to do so will result in a **$25 fee**. In the event that you cancel or reschedule an appointment 3 consecutive times, you will be dismissed from the practice.

- **No Show Policy:**
    - If a **new patient** does not come to their first appointment and provides no notice beforehand, you will not be rescheduled.
    - **Established patients** that miss their appointment without prior notice will be charged a**$50 fee**. In the event that you no show two consecutive times, or no show three times in a calendar year, you will be dismissed from the practice.

Signature of patient/representative

Date

10. LABORATORY ORDER POLICY

The providers will routinely order diagnostic testing and/or laboratory testing in order to monitor your condition. We do not perform laboratory testing in the office, but will create any necessary orders for you at check out.

When possible, we will send lab orders electronically and give you a hard copy as a backup. It is **each patient's responsibility to schedule and complete** all testing prior to your next appointment. We recommend all bloodwork be completed no less than 2 weeks prior to your scheduled visit. If you completed the testing at another doctor's office, it is the patient's responsibility to have the results sent to us or to bring a copy to our office. If you require a new lab order, there is a **$5** charge.

Signature of patient/representative

Date

11. IN-OFFICE PROCEDURES

Dr. Roberts performs thyroid ultrasounds and fine needle biopsies in office. These procedures are done on Tuesday and Friday mornings and Wednesday afternoons, only. If you choose to have the procedure done by Dr. Roberts, we will verify your benefits with your insurance beforehand can advise you of any co-pays or deductible payments upon request.

We require 48 business hours notice prior to your appointment to notify us of any changes/ cancellations. If prior notice is not given, you will be **charged $100** for the missed appointment.

Signature of patient/representative _____ Date _____

12. PRESCRIPTION POLICY

We will submit any prescriptions electronically immediately following your visit to the pharmacy of your choice. Please ensure we have the correct contact information for your pharmacy and advise the office if your location has changed. For refill requests, please contact your pharmacy.

For prior authorizations, we will gladly complete them as long as patients obtain the necessary forms from their insurance company and have them faxed to us. If unable, patients will need to find out which medications are covered by their insurance plan. This can be done by obtaining the policy formulary book or by calling their insurance directly.

Signature of patient/representative _____ Date _____

13. CGM DOWNLOAD POLICY

Patients who use a continuous glucose monitor (CGM) can allow us to download their data at each visit. Each download and interpretation has an additional cost of $75.00 and will be billed to your insurance. Any outstanding balance will be the patient's responsibility if not covered by your plan. For self pay patients, this will be discounted to $45.00 per download.

Signature of patient/representative _____ Date _____

14. REQUEST FOR RECORDS

If you request copies or transfer of medical records, you will be charged $1.00 per page up to 25 pages, and an additional $0.25 per page thereafter. This is in accordance with Florida statues.

Signature of patient/representative _____ Date _____

15. FORM COMPLETION

Our office charges a flat fee of $25.00 for the completion of any forms which require the physician to review your chart to complete. Payment is required prior to our completion.

Signature of patient/representative

Date

16. PATIENT PORTAL ACCESS

All patients will have the option to join our patient portal. We will require an email address in order to grant you access. We encourage patients to use the portal to communicate with staff when necessary. Past office notes, lab results and active prescriptions can be viewed via the portal. Patients can also check when their next appointment is and review and outstanding balances.

For questions or technical support, please call our office during business hours and we will assist you.

Signature of patient/representative

Date