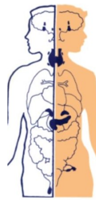


ENDOCRINE ASSOCIATES OF FLORIDA, P.A.

766 N. Sun Drive, Suite 2060
Lake Mary, FL 32746
Phone: 407-936-3860 | Fax: 407-936-3866
www.victorlrobertsmd.com

Victor L. Roberts M.D. Lucy Duque-Roberts DNP, ARNP-C

Thank you for choosing Endocrine Associates of FL, P.A. and welcome to our practice! Our staff strives to provide each patient with the best care possible and look forward to helping you meet your healthcare needs.

Enclosed, please find information you will need for your first visit. **Complete all forms entirely** and bring them to your appointment. **CHECK IN TIME FOR NEW PATIENTS IS 20 MINUTES BEFORE** your scheduled appointment time to allow us to process your paperwork. If you arrive less than 20 minutes prior, be advised we may have to reschedule.

Please remember to bring the following to your appointment:

1. **Insurance Card(s)**
2. **Driver's License or photo ID**
3. **Any updated labs and/or test results or records from your referring doctor, if available**
4. **A list of all medications and dosages you are currently taking (including over the counter medications/vitamins/supplements), as well as the name and phone number of the pharmacy you use.**
5. **Any copay, deductible and/or coinsurance you are responsible for will be collected upon check-in. Please contact our office or your insurance company prior to your appointment to confirm what copay/deductible/coinsurance you will owe.**

Upon arrival, please check in at reception. We accept Cash, Visa, MasterCard, American Express, or Discover Card. CHECKS ARE NOT ACCEPTED.

If you have an HMO, EPO, or POS plan and require a referral to see a specialist, please make sure to contact your primary care physician and have this information sent to our office **PRIOR** to your appointment. If we do not have an authorization/referral, we will have to reschedule your appointment.

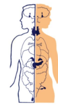
We allow up to one non-emergent reschedule for new patient appointments which will incur a **$50 fee**. If you do not come to your first appointment and do not call in advance, **you will not be rescheduled.**

If you need to contact us after hours, please call our answering service at 407-646-9827. If you have a medical emergency, dial 9-1-1 or head to the nearest emergency room.

Thank you for the opportunity and confidence in allowing us to participate in your care. We look forward to meeting you.

The Physicians and Staff

ENDOCRINE ASSOCIATES OF FLORIDA, P.A.
PATIENT REGISTRATION



PLEASE PRINT CLEARLY

LAST NAME	FIRST NAME	MIDDLE NAME

STREET ADDRESS	APT NO.	CITY	STATE	ZIP

PREFERRED LANGUAGE	DATE OF BIRTH	GENDER M [ ] F [ ] O [ ]	MARITAL STATUS (CHECK ONE) SINGLE [ ] MARRIED [ ] DIVORCED [ ] WIDOWED [ ]

PREFERRED PHONE (CHECK ONE) HOME [ ] MOBILE [ ] WORK [ ]	HOME PHONE	MOBILE PHONE	WORK PHONE

EMAIL ADDRESS	RACE (CHECK ONE) AMERICAN INDIAN/ALASKAN NATIVE [ ] ASIAN [ ] CAUCASIAN/WHITE [ ] BLACK/AFRICAN AMERICAN [ ] OTHER [ ] DECLINED [ ]	ETHNICITY (CHECK ONE) HISPANIC [ ] NON-HISPANIC [ ] DECLINED [ ]

EMPLOYMENT STATUS (CHECK ONE) FULL TIME [ ] PART TIME [ ] NOT EMPLOYED [ ] STUDENT [ ] RETIRED [ ]	OCCUPATION

EMPLOYED BY	STREET ADDRESS	CITY	STATE	ZIP

IF MINOR, PARENT/GUARDIAN NAME	RELATIONSHIP	PREFERRED PHONE

	HOW DID YOU HEAR ABOUT US? FAMILY/FRIEND [ ] PHYSICIAN [ ] INSURANCE COMPANY [ ] INTERNET [ ]	REFERRED BY

Insurance Information

POLICY HOLDER'S NAME ______________________ DATE OF BIRTH ____________

RELATIONSHIP TO PATIENT ______________________

TYPE OF INSURANCE (CHECK ONE)
GOVERNMENT [ ] EMPLOYER [ ]

INSURANCE COMPANY NAME POLICY NO.

PRIMARY ______________________ ______________________

INSURANCE CO. ADDRESS ______________________ TELEPHONE NO. ____________

SECONDARY ______________________ ______________________

INSURANCE CO. ADDRESS ______________________ TELEPHONE NO. ____________

Emergency Contact Information

NAME OF NEAREST RELATIVE OR FRIEND ______________________ RELATIONSHIP TO PATIENT ____________

ADDRESS ______________________ CITY, STATE, ZIP ____________

HOME PHONE ____________ MOBILE PHONE ____________ EMAIL ADDRESS ____________

PRIMARY CARE PHYSICIAN ______________________

ADDRESS ______________________

CITY ____________ STATE ______ ZIP ______

TELEPHONE ____________ FAX ____________

REFERRING PHYSICIAN NAME ______________________

ADDRESS ______________________

CITY ____________ STATE ______ ZIP ______

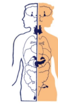
TELEPHONE ____________ FAX ____________

LIFETIME AUTHORIZATION: I understand that my medical insurance is a contract between my insurance company and MYSELF. I am responsible for payment of services at time they are rendered by Victor L. Roberts, M.D./Lucy Duque-Roberts, DNP-C. I authorize the release of any medical information necessary to process the claim for payment of insurance benefits. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I authorize my insurance company to pay medical benefits to Victor L. Roberts, M.D./Lucy Duque-Roberts, DNP-C for services rendered. Further, I authorize treatment of my condition.

______________________ ____________

Signature of Patient, or Parent, or Responsible Party Date

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

ENDOCRINE ASSOCIATES OF FLORIDA, P.A.

MEDICAL HISTORY QUESTIONNAIRE

Patient Name________________________________ DOB ________ Age _______ Date ____________

PAST MEDICAL HISTORY *(Have You Had These?)*

Yes	No		Yes	No	
___	___	High Blood Pressure	___	___	Retinopathy
___	___	Arthritis	___	___	Peptic Ulcer
___	___	Pneumonia	___	___	Gall Bladder Disease
___	___	Diabetes	___	___	Bowel Disorder
___	___	Thyroid Disease	___	___	Liver Disease
___	___	High Cholesterol	___	___	Kidney Stones
___	___	Asthma/Emphysema	___	___	Kidney Disease
___	___	Heart Disease	___	___	Stroke
___	___	Bleeding Disorders	___	___	Epilepsy
___	___	Radiation Treatments	___	___	Cataracts
___	___	Tuberculosis	___	___	Gout
___	___	Cancer	___	___	Anemia
___	___	HIV	___	___	Bladder Infections
___	___	Amputations	___	___	Neuropathy
___	___	Pituitary Disease	___	___	Parathyroid Disease

FAMILY MEDICAL IDSTORY *(Have Any Blood Relatives Ever Had?)*

Yes	No		WHO	Yes	No		WHO
___	___	Diabetes	___________	___	___	Cancer	___________
___	___	Thyroid Disease	___________	___	___	Pituitary Disease	___________
___	___	High Blood Pressure	___________	___	___	HIV	___________
___	___	Heart Disease	___________	___	___	Abnormal Bleeding	___________
___	___	Adrenal Disease	___________	___	___	Hepatitis	___________

SOCIAL HISTORY

Married___________ Single _________ Divorced____________ Widowed_____________ Separated_________

Have you used tobacco? Yes ___ No ___ # of packs per day_____ For how many years? _____

Have you used alcohol? Yes ___ No ___ How much per day_____ For how many years? _____

Do you use caffeine? Yes ___ No ___ Coffee/day______ Soda/day _____ Tea/day _____

Do you exercise regularly? Yes ___ No ___ Times/week ______

Are you on a regular diet? Yes ____ No_____

Do you use any illicit drugs or cannabis oil? Yes ____ No_____

DIABETIC 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
   If yes, how often? ______________________ Daytime or nighttime? _______________
4. Do you test your own blood sugar? Yes No times/day__________
   If yes, what meter do you use? ___________________ What is your blood sugar range? ___________
5. Have you had diabetes education? Yes No

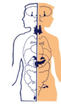
ALLERGIES *(Tothefollowing medications, please check all that apply)*

Penicillin _____ Sulfa_____ Aspirin______ Tetanus ______ Serum ________

Antibiotics _______ *If yes, please name:* ____

Other allergies, *please specify:* ____

ENDOCRINE ASSOCIATES OF FL, P.A.



HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law.

You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change. If so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may provide treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family? **If YES, please name the members allowed:**	YES	NO

Name: ______________________________ Relationship to Patient: ____________________

Name: ______________________________ Relationship to Patient: ____________________

Name: ______________________________ Relationship to Patient: ____________________

Patient Name:____

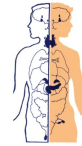
(PLEASE PRINT)

Signature of Patient or Legal Guardian: ___________________________

_________________ ______________________________________

Date Witness

ENDOCRINE ASSOCIATES OF FLORIDA, P.A.
VICTOR L. ROBERTS, M.D.
LUCY DUQUE-ROBERTS, DNP, ARNP-C
766 NORTH SUN DRIVE STE 2060, LAKE MARY, FL 32746
PH: 407-936-3860 - F: 407-936-3866



AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

I hereby authorize and request release of the following:

___ A copy of the most recent doctor notes, laboratory results, imaging.

___ Complete chart including reports, laboratory results, imaging, and medication.

MEDICAL RECORDS FROM:

Name of facility/person
to receive information from: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Phone and Fax: ______________________________

RELEASE MEDICAL RECORDS TO:

Name of facility/person
to receive information: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Phone and Fax: ______________________________

TO RECEIVING PARTY: The information is disclosed to you from records whose confidentiality is protected by law. Re-disclosure is prohibited without the written permission of the patient/client/legal representative listed above.

TO REQUESTING PARTY: I understand signing this document releases Endocrine Associates of Florida, P.A., from all legal responsibility and/or liability arising from the release of such records. Florida Statute has established guidelines and cost rates for copying of medical records. Your signature indicates your knowledge of this statement.

NOTE: PATIENT/REPRESENTATIVE MUST INITIAL APPLICABLE AREAS FOR RELEASE.

Psychiatric/phychological information _______(Initials)
Alcohol/drug/chemical information _______(Initials)
HIV tests and information pertaining to tests/treatment _______(Initials)

Patient's Name (printed): ______________ Date: ________ Address: ________________

SS# __________ DOB ___________

Patient/Guardian Signature: ________________________ Account # ________

Witness Signature: ____________________ Date: ______________