ENDOCRINE ASSOCIATES OF FLORIDA, P.A.

766 N. Sun Drive Suite 2060
Lake Mary, FL 32746
Phone: 407-936-3860 - Fax: 407-936-3866
Victor L. Roberts M.D. Lucy Duque-Roberts DNP, ARNP-C

Attn: New Patients

Thank you for choosing Endocrine Associates of FL, P.A. and welcome to our practice.

Please find enclosed information needed for your first visit. **Complete all forms entirely** and bring them to your appointment. **PLEASE ARRIVE AT LEAST 20 MINUTES BEFORE** your scheduled appointment time so that we may process your paperwork.

Please remember to bring the following to your appointment:

1. **Insurance Card(s)**
2. **Driver's License or photo ID**
3. **Labs and/or test results or records from your referring doctor. If you arrive without records or your doctor has not sent your records - you will not be seen.**
4. **A list of all your medications and dosages you are currently taking (including over the counter medications), as well as the name and phone number of the pharmacy you use. We will send prescriptions electronically to your pharmacy.**
5. **A copy of your authorization/referral from your primary care physician (if required by your insurance)**
6. **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 appointment if you are not sure what your copay, deductible, or coinsurance might be.**

We accept Cash, Visa, MasterCard, American Express, or Discover Card. NO CHECKS.

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 or brought to our office **PRIOR** to your appointment. If we do not have an authorization/referral, we will have to reschedule your appointment.

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

PATIENT LAST NAME			FIRST NAME		MIDDLE NAME
ADDRESS STREET			APT NO. CITY	STATE	ZIP CODE
SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	GENDER	PREFERRED LANGUAGE	
HOME PHONE		MOBILE PHONE		WORK PHONE	
PREFERRED PHONE (CHECK ONE) [ ] HOME [ ] MOBILE [ ] WORK	EMAIL ADDRESS				
EMPLOYED BY			OCCUPATION		
EMPLOYER'S ADDRESS			CITY, STATE		ZIP CODE
IF MINOR, PARENT/GUARDIAN NAME			RELATIONSHIP		
OCCUPATION	HOME PHONE		MOBILE PHONE	WORK PHONE	
PREFERRED PHONE (CHECK ONE) [ ] HOME [ ] MOBILE [ ] WORK	EMAIL ADDRESS				
RACE (CHECK ONE) [ ] AMERICAN INDIAN/ALASKAN NATIVE [ ] ASIAN [ ] CAUCASIAN/WHITE [ ] NATIVE HAWAIIAN/PACIFIC ISLANDER [ ] BLACK/AFRICAN AMERICAN [ ] DECLINED				ETHNICITY (CHECK ONE) [ ] HISPANIC [ ] NON-HISPANIC [ ] DECLINED	

Insurance Information

POLICY HOLDER'S NAME ______________________ RELATIONSHIP TO PATIENT ______________

DATE OF BIRTH ______________ SOCIAL SECURITY NUMBER ______________

INSURANCE COMPANY NAME — POLICY NO. OR CERTIFICATE NO.

PRIMARY ______________________ ______________________

INSURANCE CO. ADDRESS ______________________ TELEPHONE NO. ______________

SECONDARY ______________________ ______________________

INSURANCE CO. ADDRESS ______________________ TELEPHONE NO. ______________

Emergency Contact Information

NEXT OF KIN/REFERENCE INFORMATION

NAME OF NEAREST RELATIVE OR FRIEND ______________________ RELATIONSHIP TO PATIENT ______________

ADDRESS ______________________ CITY, STATE, ZIP CODE ______________

HOME PHONE ______________ MOBILE PHONE ______________ BUSINESS PHONE ______________

PRIMARY CARE PHYSICIAN'S NAME ______________	REFERRING PHYSICIAN'S NAME ______________
ADDRESS ______________	ADDRESS ______________
CITY ______________ STATE ______ ZIP CODE ______	CITY ______________ STATE ______ ZIP CODE ______
TELEPHONE ______________ FAX ______________	TELEPHONE ______________ FAX ______________

LIFETIME AUTHORIZATION: I understand that me 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./Jose M. Mandry M.D. 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./Jose M. Mandry M.D. For services rendered. Further, I authorize treatment of my condition.

Preferred Method of Payment: [ ] Cash [ ] Mastercard, Visa, Amex, Discover

***** Please note: Checks are no longer accepted.**

______________________________ ______________

Signature of Patient, or Parent, or Responsible Party — Date

ENDOCRINE ASSOCIATES OF FLORIDA, P.A.

CONTRACT FOR CARE
BETWEEN ENDOCRINE ASSOCIATES (E.A.F) AND OUR PATIENTS

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) The physicians and staff will do our best to address your concerns and expect cooperation from you, as our patient, to comply with all policies and procedures of this office.
2) We *do not* call or discuss on the phone any results for labs/tests, whether or not the results are normal or abnormal. It's the patient's responsibility to keep a follow up appointment to discuss any results. This policy has been the result of concerns on privacy, and to ascertain that there is a face to face physician-patient discussion of any results and follow up plans.
3) An appointment to see us is a mutual agreement to return for necessary care. In the event that you miss an appointment without giving us at least ***24 hours notice***, you will be charged a ***No Show Fee.***
4) In the unlikely event you **CANCEL** or **RESCHEDULE 3 CONSECUTIVE APPOINTMENTS**, you will give us no choice but to **TERMINATE** our professional relationship.
5) It is the patient's responsibility to inform that practice is they have relocated and/or are transferring their care to another physician.
6) 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 primary care physician or internist. Should you require the name of a PCP, please speak with our staff before leaving the office.
7) Your insurance contract is between you and your insurance company. It is YOUR responsibility to understand the terms and benefits of your contract. If you are unsure of these benefits, you should contact your insurance prior to your visit. **IF YOU REQUIRE A REFERRAL OR AUTHORIZATION TO SEE US, IT IS YOUR RESPONSIBILITY TO CONTACT YOUR PCP TO OBTAIN IT AND HAVE IT HERE FOR YOUR VISIT. IF YOU ARRIVE WITHOUT A REFERRAL OR AUTHORIZATION, YOUR APPOINTMENT WILL BE RESCHEDULED.**
8) Many of our patients have chronic conditions that require life-long supervision. The physicians 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 follow-up with us. Should circumstances change to require a revisit, we will be happy to see you again upon referral from your PCP.
9) We strongly believe that **THE PATIENT** has the ultimate responsibility for their healthcare. As such, the physicians will make recommendations to you and we expect that you will follow through with this advice unless we are informed otherwise. In the unlikely event that a patient does not comply with medical advice from our physicians, then we may have no choice than to terminate our professional relationship.
10) Our practice is limited to **IN-OFFICE** patient care. We **DO NOT** admit nor consult on patients who are admitted to the hospital.

______________________________________ ________________________
Patient Signature Date

ENDOCRINE ASSOCIATES OF FLORIDA, P.A.
FINANCIAL POLICY

PLEASE READ ALL INFORMATION AND SIGN

PAYMENT IS DUE AT TIME OF SERVICE unless payment arrangements have been approved in advance.

WE ACCEPT PAYMENT BY - Cash, Visa, MasterCard, American Express, or Discover Card. No Checks.
We will collect your **deductible, copay, uncovered services, or coinsurance percent responsibility at time of visit.** Please be prepared to pay BEFORE the doctor sees you.

- INSURED PATIENTS -

Our practice is not on every insurance plan and all of our physicians *do not* participate on the same plans. *You are encouraged to verify that the physician you are seeing is on your plan.* If your plan requires a *Primary Care Physician Referral* or *Pre-Authorization*, we will be unable to provide treatment or testing until authorization or referral is received. Not all services are a covered benefit of all insurance policies. *We recommend you inform yourself of any policy exclusions, as payment for non-covered services will be your responsibility.*

MEDICARE - We accept assignment on all Medicare claims. We will also file Medicare Supplement claims (except Medicaid). Patients covered by Medicare Part B must bring the Medicare card & Supplemental Policy card to the first visit. *If you switch to a Medicare Advantage Plan, please inform us immediately.*
MEDICAID - We DO NOT accept Medicaid or Medicaid Advantage plans of any kind.
HMO/PPO - Patients *must* bring the HMO/PPO card, their referral or authorization (if required), and be prepared to pay at time of service. For HMO patients, **YOU** are responsible for making sure your primary care physician has sent us the appropriate referral and YOU WILL BE RESPONSIBLE FOR ANY UNPAID BALANCES DUE TO LACK OF REFERRAL or AUTHORIZATION.
Private Insurances/Out of Network Insurances - We will file private insurance claims and out-of-network claims as a courtesy to our patients *if we can verify benefits before time of service.* Payment for the *Uninsured Portion* (Deductible & Co-Insurance) is due at the time of service.

We will file PRIMARY INSURANCES ONLY. If you have multiple insurances YOU will be responsible for submitting necessary forms for reimbursement directly to you. We will only file secondary insurance if Medicare is primary.

Your insurance will send you an explanation of benefits that explains what they paid to our office. This is a record that you must keep on file.

If your insurance denies payment on your claim, you will be asked to pay for services rendered. We accept cash, credit cards, and debit cards as forms of payment. **Any balances on your account not paid after 90 days, will be submitted to an outside collection agency** for reconciliation and you will be DISCHARGED from OUR practice.

ENDOCRINE ASSOCIATES OF FLORIDA, P.A.
FINANCIAL POLICY

- UNINSURED PATIENTS -

Patients not covered by any insurance plans or covered by insurance policies that we are unable to bill directly should expect to pay for services billed at our standard rates. The following estimates are guidelines only.

New Patients should be prepared to pay up to *$250 for the initial consultation.*

Established Patients should be prepared to pay *$85 - $100 for each follow-up visit.*

Additional Services, such as diagnostic testing and labs, may be required during any visit. These additional services are not included in the estimates above and are rendered at an additional fee.

- NO SHOW POLICY -

Patients that miss their appointments without calling and canceling or rescheduling at least twenty-four hours in advance of the appointment will be assessed a ***$25 no show fee***. New Patients will be assessed a ***$50 fee*** for rescheduling or missing an appointment. Patients that show up for their appointment more than 15 minutes late may need to reschedule their appointment to a later time/date as the original appointment time may no longer be available. In the unlikely event that you ***no show*** to 2 consecutive appointments, you will give us no choice by to terminate our professional relationship.

- REQUEST FOR RECORDS -

If you request copies or transfer of medical records you will be charged $1 per page up to 25 pages, and then an additional $0.25 per page thereafter. This is in accordance with Florida statutes.

- FORM COMPLETION -

Our office charges a flat fee of $25 for the completion of any forms which require the physician to review your chart and fill out. *Prepayment is required* before the form will be completed.

I agree to abide by the financial policy of Endocrine Associates of Florida:

____ ____________________

Patient or Guardian Signature Date

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? YES NO

If YES, please name the members allowed:

Name: ______________________ Relationship to Patient: ______________

Name: ______________________ Relationship to Patient: ______________

Name: ______________________ Relationship to Patient: ______________

Patient Name: ________________________________

(PRINT NAME PLEASE)

Signature of Patient or Legal Guardian: ________________________________

______________ Date

______________________ Witness

ENDOCRINE ASSOCIATES OF FL, P.A.
PATIENT PORTAL CONSENT FORM

By signing below, I authorize Endocrine Associates of Florida P.A. to send email communications regarding the patient portal to the email address identified below and give my expressed consent for my medical information to be made available to me using MyHealthRecord.com. I understand that I have the right to receive a completed copy of this consent.

Patient Name:____

Last Name   Middle Initial   First Name   Date of Birth

Address:____

Street   City   State

Zip

Please clearly print or type the email address authorized to receive the email invitation:

[ ]

Please clearly re-print or re-type the email address authorized to receive the email invitation:

[ ]

Complete the following if the email address does not belong to the patient:

Recipient:____

Last Name   Middle Initial   First Name

____

Relationship to the Patient

I understand that my health information is protected by federal and state law. This consent applies to records which may contain information related to testing, diagnosis or treatment for conditions and are protected by Florida Law. This consent will remain in effect unless I deactivate my account or written notice is provided to Endocrine Associates of Florida, P.A.

I understand that my username and password will be unique to my health information and sharing my username and password may grant others access to my health information. I further understand that any health information disclosed as a result of sharing my username and password may no longer be protected under federal or state law and could be further released by the individual who receives the information.

I understand that I may refuse to sign this consent and such refusal will not prohibit me from receiving treatment, payment for my treatment, enrollment in a health plan, or eligibility for benefits. I further understand that my refusal to sign this consent will not prevent me from receiving a copy of my medical records.

☐ **YES** I do wish to access my medical information and give my expressed consent for Endocrine Associates of FL, P.A. to make my medical information available to me using MyHealthRecord.com.

☐ **NO** I do not wish to access my medical information using MyHealthRecord.com.

Patient or Representative Signature:		Witness Signature:	
Signature		Signature	
Print Name	Date	Print Name	Date
Relationship to Patient*			

*Legal authority must be verified when an individual is signing on behalf of the patient

Portal can be accessed at https://myhealthrecord.com/Portal/SSO

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: ____

RELEASE MEDICAL RECORDS TO:
Name of facility/person
to receive information: ____

Address: ____

City, State, Zip: ____

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/psychological 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: ______________

ENDOCRINE ASSOCIATES OF FLORIDA, P.A.

Date____________ DOB_____________ Age_______ Patient Name_________________________________

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 HISTORY (*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 _______ Cola/day _______ Tea/day ________

Do you exercise regularly? Yes ___ No ___ Are you on a regular diet? ______________________________

Do you use any illicit drugs or cannabis oil? Yes ___ No ___

LIST CURRENT MEDICATIONS

Name	Dose	Amount Take Each Day

ALLERGIES (*To the following medications, Please Check*)

Penicillin _____ Sulfa ______ Aspirin ______ Tetanus ______ Serum ______

Antibiotics ______ - *Please Name*: ____

Other - *Please Specify*: ____

ENDOCRINE ASSOCIATES OF FLORIDA, P.A.

Date____________ DOB____________ Age_______ Patient Name________________________________

PREVIOUS SURGICAL PROCEDURES

			Appx. Date
Tonsillectomy	Yes ____	No ____	____________
Appendectomy	Yes ____	No ____	____________
Hysterectomy	Yes ____	No ____	____________
Cholecystectomy *(removal of Gall Bladder)*	Yes ____	No ____	____________
Other	Yes ____	No ____	____________

REVIEW OF SYSTEMS (*In Last Six Months*)

SKIN

Dry	Yes ____	No ____
Moist	Yes ____	No ____
Rash	Yes ____	No ____
Normal	Yes ____	No ____
Open Wounds	Yes ____	No ____
Excessive Bruising	Yes ____	No ____

CARDIAC / RESPIRATORY

Shortness of Breath	Yes ____	No ____
Chest Pain	Yes ____	No ____
Heart Palpitations	Yes ____	No ____
Persistent Cough	Yes ____	No ____

GASTROINTESTINAL

Ulcers	Yes ____	No ____
Liver Disease	Yes ____	No ____
Diarrhea	Yes ____	No ____
Constipation	Yes ____	No ____
Blood in Stool	Yes ____	No ____

KIDNEYS

Stones	Yes ____	No ____
Kidney Infection	Yes ____	No ____
Bladder Infection	Yes ____	No ____
Blood in Urine	Yes ____	No ____

NEUROLOGICAL

Severe Headaches	Yes ____	No ____
Confusion	Yes ____	No ____
Tingling	Yes ____	No ____
Numbness	Yes ____	No ____

ENDO

Excessive Thirst	Yes ____	No ____
Increased Urination	Yes ____	No ____
Rising to Void, *(more than once a night)*	Yes ____	No ____

General Review

Weight Change	Yes ____	No ____
Extreme Fatigue	Yes ____	No ____
Fainting	Yes ____	No ____
Dizziness	Yes ____	No ____
Impaired Sight	Yes ____	No ____
Nose Bleeds	Yes ____	No ____
Anxiety	Yes ____	No ____

Female Reproductive

Age of Menstruation	____________
Is it Regular	____________
No. of Pregnancies	____________
Children Born Alive	____________
Breast Discharge	____________
Date Last Menstrual Period	____________
Date Last Mammogram	____________

Male Reproductive

Prostate Disorder	Yes ____	No ____
Testicular Mass	Yes ____	No ____
Impotence	Yes ____	No ____

THYROID

Has Voice Changed	Yes ____	No ____
Difficulty Swallowing	Yes ____	No ____
Nodule/Growth of Thyroid	Yes ____	No ____
Painful Thyroid	Yes ____	No ____
Goiter Problem	Yes ____	No ____
Hair - Coarse	Yes ____	No ____
- Normal	Yes ____	No ____
- Thin	Yes ____	No ____
- Loss of	Yes ____	No ____

Vaccination

Tetanus Vaccine *(last 10 years)*	Yes ____	No ____

IMAGING

Thyroid Ultrasound	Yes ____	No ____	MRI of Pituitary	Yes ____	No ____
Thyroid Uptake & Scan	Yes ____	No ____	CT Scan of Pituitary	Yes ____	No ____
Whole Body Scan	Yes ____	No ____	MRI/CT Adrenal	Yes ____	No ____
Parathyroid Scan	Yes ____	No ____	Dexa Scan	Yes ____	No ____