Sohail H. Ali, M.D.
Julie A. Bauer, M.D.
Penny S. Glickman, M.D.
Carlos A. Pacheco, M.D.
Kenneth Rodriguez, M.D.

Central Florida Endocrine and Diabetes Consultants, P.A.

Tel: (407) 629-4901 • Fax: (407) 629-0168
www.floridaendocrine.com

635 N. Maitland Ave.
Maitland, FL 32751

117 W.Underwood
Orlando, FL 32806

1000 Executive Blvd. Ste. 8
Oviedo, FL 32765

WELCOME TO OUR OFFICE

The physicians and staff at Central Florida Endocrine and Diabetes Consultants 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 and medical records.**
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: **407-629-4901**

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.
3. You may use the patient portal to check your appointment date and times.
4. We fill your prescriptions electronically. Should you need a refill please contact your pharmacy.
5. We encourage you to communicate through the patient portal .
6. Once you have selected your physician, **we do not switch physicians within the practice**
7. Unless otherwise stated Lab test results will be available thru the patient portal after your follow up appointment.

LABORATORY POLICIES

1. **<u>For your safety and for HIPAA Compliance , Only the patient is allowed in the drawing room</u>.** If you have small children, please make arrangements accordingly.
2. You will be taken to the lab according to your appointment time, not your arrival time. Arriving early will not expedite your visit.
3. Fasting patients are allowed to drink water, unless otherwise advised.
4. We make every effort to combine orders from other physicians or if need be, send them out to the appropriate lab per your insurance.

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. **<u>Co-payments and account balances are collected at the check-in window prior to your visit</u>**.
3. If your insurance carrier does not remit payment within 30 days, the balance will be due in full from you.
4. Occasionally your doctor may order a laboratory test that our laboratory does not perform and it must be sent to an outside laboratory. When this occurs the outside laboratory will bill your insurance or you directly. If you receive a bill from them, please contact them directly. Outside laboratories do not bill through our office. They have their own billing service.
5. Occasionally your doctor may order a medically necessary laboratory test not covered by Medicare. If this occurs, you will be advised in advance of the cost of this test and you will be asked to sign an Advanced Beneficiary Notice. At that time the necessity of the test will be explained to you and you will have the option to accept or reject this service. If you accept this test the payment will be your responsibility.
6. 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.
7. We don’t file secondary insurance, unless supplement to Medicare or Medicare is the secondary payer.
8. Self-pay patients are required to pay in full at time of services. We offer a discount to payments paid at the time of service.
9. 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.
10. Our return check fee is $50.00

Sohail H. Ali, M.D.
Julie A. Bauer, M.D.
Penny S. Glickman, M.D.
Carlos A. Pacheco, M.D.
Kenneth Rodriguez, M.D.

Central Florida Endocrine and Diabetes Consultants, P.A.

Tel: (407) 629-4901 • Fax: (407) 629-0168
www.floridaendocrine.com

635 N. Maitland Ave.
Maitland, FL 32751

117 W.Underwood
Orlando, FL 32806

1000 Executive Blvd. Ste. 8
Oviedo, FL 32765

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

STREET ADDRESS	CITY	STATE	ZIP

SEX ❒ M ❒ F	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 ❒ INSURANCE ❒ PHYSICIAN ❒ INTERNET	EMPLOYER'S PHONE ( )

REFERRED BY	FAMILY PHYSICIAN

INSURANCE INFORMATION			SECONDARY CARRIER		
INSURANCE COMPANY	PHONE ( )		INSURANCE COMPANY	PHONE ( )	
ADDRESS			ADDRESS		
CITY/STATE/ZIP			CITY/STATE/ZIP		
POLICY / ID NUMBER	GROUP #		POLICY / ID NUMBER	GROUP #	
INSURED'S LAST NAME	FIRST NAME	D.O.B.	INSURED'S LAST NAME	FIRST NAME	D.O.B.
RELATIONSHIP TO INSURED ❒ SELF ❒ HUSBAND ❒ PARENT ❒ WIFE ❒ OTHER	EMPLOYER'S. INSURANCE PLAN ❒ YES ❒ NO		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:____________________

Sohail H. Ali, M.D.
Julie A. Bauer, M.D.
Penny S. Glickman, M.D.
Carlos A. Pacheco, M.D.
Kenneth Rodriguez, M.D.

Central Florida Endocrine and Diabetes Consultants, P.A.

Tel: (407) 629-4901 • Fax: (407) 629-0168
www.floridaendocrine.com

635 N. Maitland Ave.
Maitland, FL 32751

117 W.Underwood
Orlando, FL 32806

1000 Executive Blvd. Ste. 8
Oviedo, FL 32765

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 consistently 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 Central Florida Endocrine.

_________________________________ _____________________

Signature of Patient Date

3. ASSIGNMENT OF INSURANCE AND MEDICARE BENEFITS:

I hereby authorize payment directly to Central Florida Endocrine & Diabetes Consultants, P.A. 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 Central Florida Endocrine & Diabetes Consultants, P.A. 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.)

Sohail H. Ali, M.D.
Julie A. Bauer, M.D.
Penny S. Glickman, M.D.
Carlos A. Pacheco, M.D.
Kenneth Rodriguez, M.D.

Central Florida Endocrine and Diabetes Consultants, P.A.

Tel: (407) 629-4901 • Fax: (407) 629-0168
www.floridaendocrine.com

635 N. Maitland Ave.
Maitland, FL 32751

117 W.Underwood
Orlando, FL 32806

1000 Executive Blvd. Ste. 8
Oviedo, FL 32765

PATIENT CONSENT

FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In connection with the medical services I am receiving from Central Florida Endocrine and Diabetes Consultants, P.A. 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.

Central Florida Endocrine and Diabetes Consultants, P.A. 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.

Central Florida Endocrine and Diabetes Consultants, P.A. 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: ______________________________

Sohail H. Ali, M.D.
Julie A. Bauer, M.D.
Penny S. Glickman, M.D.
Carlos A. Pacheco, M.D.
Kenneth Rodriguez, M.D.

Central Florida Endocrine and Diabetes Consultants, P.A.

Tel: (407) 629-4901 • Fax: (407) 629-0168
www.floridaendocrine.com

635 N. Maitland Ave.
Maitland, FL 32751

117 W.Underwood
Orlando, FL 32806

1000 Executive Blvd. Ste. 8
Oviedo, FL 32765

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

Sohail H. Ali, M.D.
Julie A. Bauer, M.D.
Penny S. Glickman, M.D.
Carlos A. Pacheco, M.D.
Kenneth Rodriguez, M.D.

Central Florida Endocrine and Diabetes Consultants, P.A.

Tel: (407) 629-4901 • Fax: (407) 629-0168
www.floridaendocrine.com

635 N. Maitland Ave.
Maitland, FL 32751

117 W.Underwood
Orlando, FL 32806

1000 Executive Blvd. Ste. 8
Oviedo, FL 32765

CONSENT TO DISCLOSE MEDICAL INFORMATION

Name: ______________________________ D.O.B. ____________

____

Please check one of the following:

☐ I give permission to the employees of Central Florida Endocrine & Diabetes Consultants, P.A. 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)

CENTRAL FLORIDA ENDOCRINE & DIABETES CONSULTANTS, P.A.

NEW PATIENT MEDICATION LIST

Name: ____ Date of Birth ___________________

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

Drug Allergies: ____

____

____

cfe006

____

Name of Preferred Pharmacy

rev 09-22