Children's Endocrine & Diabetes Care, INC
1447 Medical park Blvd. suite 104
Wellington FL, 33414

Patient Information

Patient name: ____
Last *first* *middle*

*Social Security No:*______________ *Birthdate:*__________ *Age:*____ *Male/Female:*__________

*Home No:*________________ *Cell No:*____________ *Primary Care Physician*__________

Patient address:____
Street *City* *State* *Zip*

*Email*______________________________

Parents/Guardian

*Father's name:*____________________ *SS#:*__________ *Birthdate:*__________

*Address:*________________________ *Home Phone:*________________

*Employer:*________________________ *Cell phone:*________________

*Mother's name:*____________________ *SS#:*__________ *Birthdate:*__________

*Address:*________________________ *Home phone:*________________

*Employer:*________________________ *Cell phone:*________________

*Emergency Contact:*____________________ *Phone:*________________

Insurance Information

*Insurance Co:*______________________________ *Phone:*______________

*Policy #:*______________ *Group #:*__________ *Name of Insured:*__________

Pharmacy Information

*Preferred Pharmacy:*______________________________ *Phone:*______________

*Address:*____

Authorization of Services and Payment Agreement

Patients name:____
Last ***first*** ***middle***

The signature below serves as authorization for services by Children's Endocrine & Diabetes Care, Inc, for the above named minor child, and release of information necessary to file insurance and assign benefits otherwise payable to the policy holder, the doctor, or the group indicated on the claim.

I also understand that I am financially responsible for all co-payments, deductibles or services not covered by my insurance plan and that it is my responsibility to be informed of the cost for such services. I agree to reimburse the doctor for these services at the time they are rendered. (A copy of the signature is as valid as the original.)

Signature:______________________ ***Date:***________________

Name:______________________
Print

Medical and Family History

Name of patient:______________________________Date:__________________

Patient's Birth history:

Complications during pregnancy (include medications taken and if any complications):____
____.
Length of pregnancy:________________Type of delivery:_______________
Birth weight:__________________Birth length:____________________
Any history of stillbirths or miscarriages in the family?___________________

Patient's Medical history:

Childhood illnesses:____
Surgeries:____
Hospitilzations:____
Allergies:____
Medications currently taking:____
Trauma:____

Patient's Family History:

Any chronic medical conditions in the family and in whom:

Diabetes NO/YES:__________________
Short stature NO/YES:______________
Thyroid disorders NO/YES:___________
Early puberty NO/YES:______________
Adrenal disorders NO/YES:___________

Obesity: NO/YES:____________________
High cholesterol: NO/YES:_____________
Cancer NO/YES:______________________
Excess hair in women NO/YES:__________
High blood pressure NO/YES:___________

Patient's Biological Parents Only:

Father: Ht.______Wt._____
Mother: Ht.______Wt._____

Brothers: Age:______Ht._____
Age:______Ht._____

Sisters: Age:______Ht.______
Age:______Ht.______

Father's side: Grandfather: Ht._______
Grandmother: Ht._______

Mother's side: Grandfather: Ht._______
Grandmother: Ht._______

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Confirmation of Appointments and Information

I give permission for protected health information regarding my child, ____________________,
(name of child)
be released for the purposes of confirming appointments, reviewing lab results and other related procedures that pertain to my child's association with this office be released to the following:

[ ] AN ANSWERING MACHINE OR VOICE MAIL AT HOME____________________

[ ] AN ANSWERING MACHINE OR VOICE MAIL AT WORK____________________

OR FAXED TO:

HOME:____________________

WORK:____________________

OR TO THE FOLLOWING PERSONS: (NOTE RELATIONSHIP TO PATIENT)

____

____

I am aware that without a court order Childrens Endocrine & Diabetes Care cannot legally refuse to disclose my child's protected medical information, even if requested by me, to my child's other biological, adoptive or legal parent. All legal guardians must be able to provide picture identification.

I give permission for ____________________'s protected health
(name of child)
Information be disclosed for the purposes of health care to [ ] any health specialist
[ ] the school he/she is attending

I am releasing the office of Children's Endocrine & Diabetes Care from any liability concerning the release of any of this information regarding my child's health care that my be included in the medical record.

Name of patient____________________

Date of Birth____________________

Witness (signature)____________________

Witness (print)____________________

Name of guardian____________________

Relationship to patient____________________

SS#____________________DOB____________________

Address____________________

City____________________

Phone____________________ Fax____________________

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Children's Endocrine & Diabetes Care, INC for the purpose of diagnosing or providing treatment to my child, obtaining payment for heath care bills or to conduct health care operation of Children's Endocrine & Diabetes Care, INC. I understand that diagnosis or treatment of my child by Children's Endocrine & Diabetes Care, INC may be conditioned upon my consent as evidenced b y my signature on this document and as duly noted below in paragraph 7.

My child's "protected health information, (PHI)), means health information, including demographic information, collected from my child and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my child's past, present or future physical or mental health or condition and identifies my child or there is a reasonable basis to believe the information may identify my child.

I understand that protected health information may serve as
---a basis for planning care and treatment
---a means of communication among health professionals who contribute to my child's care
---a source of information for billing purposes and for third party payers to verify services were provided
---a tool for assessing quality and reviewing competency of the healthcare professionals
---a tool to assess treatment safety and outcomes through pharmaceutical registries or the FDA

I authorize Children's Endocrine & Diabetes Care, INC to release clinical data for the purpose of research related to drug effectiveness and/or adverse events and to meet FDA requirements with the understanding that the identifier will be limited to a numeric assignment or initials/date of birth.

Your Rights:
1) I understand I have the right to request, in writing, a restriction as to how my child's protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice.
2) I have the right to revoke this consent, in writing, at any time, except to the extent that Children's Endocrine & Diabetes Care, INC has taken action in reliance on this consent.
3) I understand that by refusing to sign this consent, in writing, Children's Endocrine & Diabetes Care, INC may refuse to treat my child as permitted by Section 164.506 of the code of Federal Regulations.

I understand and have been provided with a Notice of Privacy Practices for Children's Endocrine & Diabetes Care, INC prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operation of Children's Endocrine & Diabetes Care, INC. The Notice of Privacy Practices for Children's Endocrine & Diabetes Care, INC is also provided in the waiting room area. This Notice of Privacy Practices also described my rights and Children's Endocrine & Diabetes Care, INC duties with respect to my protected health information.

I further understand that Children's Endocrine & Diabetes Care, INC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices in accordance with Section 164.520 of the Code of Federal Regulations. Should Children's Endocrine & Diabetes Care, INC change their notice I will be given a copy of the revised notice of privacy practices for my review and acceptance at the time of my next appointment.

I fully understand and accept/decline the terms of this consent.

______________________ Print name of patient or representative	______________________ Signature of patient or representative
______________________ Name of patient	______________________ Representative's relationship to patient
______________________ Date	

For official use only

[ ] Consent received by ________________on________________

[ ] Consent refused by guardian/patient and treatment refused as permitted.

[ ] Consent added to patient's medical record on________________________.

Children's Endocrine & Diabetes Care, INC
1447 Medical park Blvd. suite 104
Wellington FL, 33414

Dear Families:

WELCOME TO OUR PRACTICE! We will do our best to meet your medical expectations. Please be aware we have the following office policies:

1) After hours calls: phone calls to the doctor after hours should be for emergencies only. Please do not call for refills on evenings, weekends or holidays. Please notify our office one week before your prescriptions expire for refills. Emergencies include: vomiting, seizures, moderate or large ketones, or low blood sugar not responding to treatment. Non-emergent calls made after hours will incur a fee of $30.00.
2) Blood sugars can be faxed in between visits to 561-792-1521.
3) **A $25.00 charge will be charged to your account for any appointment cancelled the same day or missed without at least 24 hour notice.**
4) Letters written by the doctor must be requested in writing and will incur a charge of $50.00.
5) Request for medical records must be in writing. As per the Florida Rule 59R-10.003 there is a $1.00 per page charge which must be received before the chart is copied.
6) All referrals, co-pays and deductibles will be collected at the time of check-in.
7) The parent/guardian with the patient at the time of the visit is financially responsible for payment. If you are unable to sign the financial statement forms, your appointment will be rescheduled.
8) A $20.00 charge for all returned checks will be incurred as per Florida law.

I acknowledge that I have read the above policies.

____
Patient name

____
Guardian/parent name and signature

____
Date

____
Relationship to patient

Children's Endocrine & Diabetes Care, Inc.
1447 Medical Park Blvd. Suite 104
Wellington, FL 33414
Off: 561-792-1525
Fax: 561-792-1521

****Request to Release, Copy, or Inspect Protected Health Information****

Patient Name: ______________________ **Date of Birth:** ____________

Patient Address: ______________________

______________________ **Phone #:** ____________

For Record Release or Copy: By signing this authorization, I authorize the party listed below to use and/ or disclose certain protected health information (PHI) about me/my child.

This authorization permits:

to use or disclose to

______________________ Provider's Name	______________________ Provider's Name
______________________ Street Address	______________________ Street Address
______________________ City, State ZIP	______________________ City, State ZIP
______________________ Phone #	______________________ Phone #
______________________ Fax #	______________________ Fax #

Information to be Released/Copied: ( ) All pertinent medical records ( ) Progress Notes ( ) Lab Results ( ) Bone age ( ) History & Physical ( ) MRI results ( ) Ultrasound results ( ) CT results ( ) Other____________

Information to be excluded: ( ) Mental Health Records ( ) Drug/Alcohol Treatment ( ) HIV testing ( ) Sexual Assault/ Victimization Records

Reason for Record Release or Copy: ( ) Personal Copy **{See Below/ Charges Apply}** ( ) Over age 21 ( ) Insurance Change ( ) Moving/ Changing Providers ( ) Referral to Specialist ( ) Unhappy with Practice **(please state why):**______________________
( ) Other______________________

For Patient or Guardian Inspection/ Copy Requests: ( ) Check Here
I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is: **$1.00 per page for the first 25 pages, then $.25 for each page thereafter.**

______________________ Signature of Patient or Legal Guardian

______________________ Date*

______________________ Print Name of Patient or Legal Guardian

***Inspection requests are valid on the date of signature only**
***Release /Copy requests expire 30days from signature date**

Informed Consent for Telemedicine Services by Children's Endocrine and Diabetes Care

Telemedicine involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her local healthcare site (i.e. home) while the physician consults and obtains test results at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, the consultant may determine that the transmitted information is of inadequate quality, thus necessitating a face-to-face meeting with the patient, or at least a rescheduled video consult;
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

By signing this form You acknowledge that you understand and agree with the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine, which identifies me, will be disclosed to researchers or other entities without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
4. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
6. I understand that I have the right to inspect all information obtained and/or recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction.

I have read this document carefully, and understand the risks and benefits of the teleconferencing consultation and have had my questions regarding the procedure explained and I hereby give my informed consent to participate in a telemedicine visit under the terms described herein.

By checking the Box containing "INFORMED CONSENT FOR TELEMEDICINE SERVICES" I hereby state that I have read, understood, and agree to the terms of this document.

Signature of Patient
(or person authorized
to sign for patient):_______________________________________ Date:_______________

If authorized signer,
relationship to patient_______________________________________ Date_______________

Children's Endocrine & Diabetes Care, Inc.
1447 Medical Park Blvd, Ste 104
Wellington, FL 33414

From the desk of: Middey Damian, M.D., FAAP

Off: 561-792-1525
Fax: 561-792-1521

INFORMED CONSENT PURSUANT TO FLORIDA STATUES SECTION 465.51

Examination and palpation of the external genitalia is a part of the complete physical exam performed by a pediatric endocrinologist to document appropriate growth and development. Florida has passed a new law that requires a health care practitioner that is examining or treating a patient's pelvic region will need to obtain written consent.

CONSENT FOR EXAMINATION OF EXTERNAL GENITALIA

By signing below, the patient or the patient's legal representative has voluntarily agreed to the external genitalia examination by a health care practioner. This would include examination of the external genitalia including penis, scrotum, vagina, labia, perineal area, perianal area, rectum. Risks to the examination include discomfort, and not signing the consent would lead to delay of diagnosis of a medical condition. I acknowledge that this consent was given freely and voluntarily. By signing below, I confirm that I consent to Children's Endocrine and Diabetes Care conducting a pelvic examination.

Date________________ Patient Name:__________________________________

____

Signature of Parent, Guardian Legally Authorized Representative of minor or Patient over age 18