Welcome to Our Practice

New patient packet for insurance patients. Please read each section, initial where asked, and sign at the end of each form.

Before you sign: a friendly note

Thank you for choosing us for your care. These forms explain how we care for you, how we protect your information, and how billing works. Please take a few minutes to read them.

We understand that these policies may not be the right fit for everyone, and that is completely okay. However, we can only see patients who agree to **all** of the terms in this packet. If you are not comfortable with any part of it, please call us at **772-398-7814** and cancel your appointment right away, **at least 48 hours before your appointment time**, so that you are not charged our **$100 no-show fee**.

If you have questions about anything here, please call us before your visit. We are happy to help.

You, the patient, are the most important person in our office. We are committed to providing you with the best possible medical care, and excellence is our goal. We offer a full range of services with a highly trained, knowledgeable staff. Please do not hesitate to ask us any questions about your health plan or medical care.

Office hours	Monday to Thursday, 8:00 a.m. to 5:00 p.m. Friday, 8:00 a.m. to 12:00 p.m.
Prescriptions	Please have your pharmacy send prescription and refill requests, or call us during business hours. No walk-ins. Please allow at least four business days.
Appointments	• To make sure you get accurate, safe medical guidance, all questions and concerns are handled through a scheduled appointment or by calling the office. • If you cannot keep your appointment or will be late, please call us as soon as possible. We hold appointment times for 10 minutes. After that, we will need to reschedule, and a no-show and/or late fee may apply. • We are sorry for any wait. We do our best to see you on time and give you the finest care possible. • **Forms:** Please complete this packet before your visit, either by e-signing online at tcendo.com (Patient Forms) or by printing, filling out and bringing it with you. If your forms are not completed in advance, please arrive **30 minutes before** your appointment time to fill them out. If you arrive later than that, we may need to reschedule your visit, depending on how busy the schedule is. • Please bring a photo ID, your insurance card(s), any previous records (lab results, diagnostic studies) and a current medication list. • Please schedule your follow-up appointment before you leave.
Financial policy	Even with insurance, a signed financial agreement is required. Copays and any past-due balances are due at the time of your visit. Missed appointments not cancelled at least 48 hours in advance are subject to a $100 no-show fee.

Patient Information

LEGAL LAST NAME | LEGAL FIRST NAME | MI

PREFERRED FULL NAME (IF DIFFERENT) | PREFERRED PRONOUNS

STREET ADDRESS

CITY | STATE | ZIP

CELL PHONE | HOME PHONE (LANDLINE) | EMAIL ADDRESS

DATE OF BIRTH (MM/DD/YYYY) | SEX ASSIGNED AT BIRTH | SOCIAL SECURITY NUMBER

Sexual orientation ☐ Straight ☐ Lesbian, gay, or homosexual ☐ Bisexual ☐ Do not know ☐ Choose not to disclose ☐ Something else

Gender identity ☐ Female ☐ Male ☐ Transgender female to male ☐ Transgender male to female ☐ Genderqueer ☐ Choose not to disclose

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Hispanic ☐ Choose not to disclose ☐ Other

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred language ☐ English ☐ Spanish ☐ ASL ☐ French ☐ Haitian Creole ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Mandarin ☐ Korean ☐ Japanese ☐ Swahili ☐ Other

IF YOU CHOSE "SOMETHING ELSE" OR "OTHER" ABOVE, PLEASE DESCRIBE

Responsible Party (if not self; used for patient balance statements)

Responsible party ☐ Self ☐ Parent / guardian / guarantor ☐ Another patient

LAST NAME | FIRST NAME | MI

DATE OF BIRTH | SEX | SOCIAL SECURITY NUMBER | PHONE

ADDRESS | CITY, STATE | ZIP

Insurance: Please bring your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

Emergency Contact

LAST NAME | FIRST NAME | RELATIONSHIP TO PATIENT

PHONE | HOME PHONE | WORK PHONE

ADDRESS | CITY, STATE | ZIP

Do you have a living will? ☐ Yes ☐ No

General Consent for Care and Treatment

To the patient: You have the right to be informed about your condition and any recommended surgical, medical or diagnostic procedure, so that you can decide whether to undergo a suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This form asks for your permission to perform the evaluation needed to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent gives us your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you indicate that (1) you intend this consent to continue even after a specific diagnosis has been made and treatment recommended, and (2) you consent to treatment at this office or any other satellite office under common ownership. This consent remains fully effective until it is revoked in writing. You have the right to discontinue services at any time.

You have the right to discuss the treatment plan with your physician, including the purpose, potential risks and benefits of any test ordered for you. If you have concerns about any test or treatment recommended by your health care provider, we encourage you to ask questions. I voluntarily request a physician and/or advanced practice provider (nurse practitioner, physician assistant or clinical nurse specialist), and other health care providers or their designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition that brought me to this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms before the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to their contents.

PATIENT OR REPRESENTATIVE SIGNATURE | DATE

PRINTED NAME OF PATIENT OR REPRESENTATIVE | RELATIONSHIP TO PATIENT (SELF, PARENT, GUARDIAN)

Patient HIPAA Acknowledgement and Consent

Please initial each section to show you have read and agree to it.

Notice of Privacy Practices

INITIALS

I acknowledge that I have received the Notice of Privacy Practices, which describes how the practice may use and disclose my health care information for treatment, payment, health care operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer named in the notice with any question or complaint. I understand that this information may be disclosed electronically by the provider and/or the provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practices.

Consent to Email, Cell Phone or Text for Appointment Reminders and Other Health Care Communications

INITIALS

Some messages related to your visit may be sent regardless of explicit consent, including instructions or communications related to your care, such as post-procedure instructions, follow-up instructions, educational information and prescription information. For other types of communications, I consent to receiving telephone calls, text messages or voicemails by or on behalf of the practice at the email, telephone number or text address in my patient record, including any address or number forwarded or transferred from them.

Other health care communications may include, but are not limited to, communications to family or designated representatives about my treatment or condition, appointment reminders, communications about insurance or billing, and requests for feedback about my visit through satisfaction surveys and/or public-facing reviews. I authorize these communications to be sent using an automated dialing system or prerecorded messages, by the practice or someone calling on its behalf, even if my number is listed on a federal or state "do not call" registry. To the extent these communications could be considered telephone sales calls, solicitations or advertisements, I consent to receiving them. I understand that I am not required to consent to these communications in order to receive health care services.

Note: This location uses an electronic health record (EHR) that will update all of your demographics and consents with the information you just provided. This information will also be updated at all affiliated locations that share the EHR and with which you have a relationship. My consent to access the patient portal is separate from the consent in this section.

Consent for Photographs or Other Recordings for Security and/or Health Care Operations

INITIALS

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security and/or the practice's health care operations (for example, quality improvement). I understand that the practice owns these images and recordings, that I may request access to or copies of them when technologically feasible unless prohibited by law, and that they will be securely stored and protected. Images or recordings that identify me will not be released or used outside the practice without my specific written authorization or that of my legal representative, unless otherwise permitted or required by law.

Communications About My Health Care

INITIALS

I agree that the provider, an agent of the provider, or an independent physician's office may contact me to schedule necessary follow-up visits recommended by my treating physician.

Release of Information

INITIALS

I permit the practice and the physicians or other health professionals involved in my inpatient or outpatient care to release health care information for treatment, payment or health care operations.

- Health care information may be released to any person or entity responsible for payment on my behalf to verify coverage or payment questions, or for any other purpose related to benefit payment. It may also be released to my employer's designee when services are related to a workers' compensation claim.
- If I am covered by Medicare, I authorize release of health care information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim, or to the appropriate state agency for payment of a Medicaid claim. This may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summaries.
- Federal and state laws may permit this practice to take part in organizations with other health care providers, insurers and/or other health care industry participants and their subcontractors, so they can share my health information with one another to improve the accuracy and availability of my health records, reduce the time needed to access my information, aggregate and compare my information for quality improvement, and for other purposes permitted by law. I understand this practice may be a member of one or more such organizations. This consent specifically includes information about psychological, psychiatric and intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases, including but not limited to blood-borne diseases such as HIV and AIDS.

Disclosures to Friends and/or Family Members

Do you want to designate a family member or other person with whom your provider may discuss your medical condition? If yes, I give permission for my protected health information to be disclosed for the purpose of communicating results, findings and care decisions to the people listed below.

Name	Relationship	Contact number

The patient or representative may revoke or change this authorization in writing at any time.

I certify that I have read and fully understand the statements on all pages of this HIPAA acknowledgement and consent, and consent fully and voluntarily to their contents.

PATIENT OR REPRESENTATIVE SIGNATURE

DATE

PRINTED NAME OF PATIENT OR REPRESENTATIVE

RELATIONSHIP TO PATIENT (SELF, PARENT, GUARDIAN)

HIPAA Consent and Privacy Summary

This notice explains how your medical information may be used, when it may be shared, and your rights under HIPAA. Please review it carefully.

How we use and share your medical information

We may use and share your health information as allowed by law for:

Treatment	• Providing your medical care • Coordinating care with other doctors, labs or specialists • Requesting and reviewing medical records related to your care
Payment	• Billing and payment processing • Insurance eligibility, coverage decisions and medical necessity reviews • You remain responsible for any charges not covered by insurance
Health care operations	• Quality improvement and staff training • Practice operations, audits, licensing and compliance • Working with billing, transcription and other business partners who are required to protect your privacy

Other situations where information may be shared (as required by law)

We may also share your information without your written permission when required or allowed by law, including for:

- Public health and disease prevention
- Reporting communicable diseases
- Health oversight activities (audits, investigations)
- Abuse, neglect or domestic violence reporting
- FDA safety reporting
- Legal proceedings and law enforcement
- Coroners, funeral directors and organ donation
- Approved research studies
- Serious threats to health or safety
- Military, national security or workers' compensation
- Correctional facility care, if applicable

Sharing with family or others involved in your care

Unless you object, we may share limited information with family members or close contacts involved in your care or payment, and with people helping during emergencies or disaster relief. If you are unable to communicate, we may use professional judgment to act in your best interest.

Uses that require your written authorization

Any other use or disclosure of your medical information not described above requires your written authorization, which you may revoke in writing at any time (except for information already shared).

Your rights

- **Review and obtain a copy** of your medical records (fees may apply)
- **Request corrections** to your medical record
- **Request limits** on how your information is used or shared (not all requests can be honored)
- **Request confidential communications** (such as contact by mail or an alternate phone)
- **Receive a list** of certain disclosures made outside of treatment, payment or operations
- **Receive a copy** of this notice at any time

Our responsibilities

- We are required by law to protect your medical information
- We must follow the terms of this privacy notice
- We may update this notice as laws or practices change
- Updated versions are available on request or through our office

Authorization to obtain records

I authorize Diabetes, Thyroid & Hormone Center of the Treasure Coast to obtain relevant medical records necessary for my care.

By signing below, I acknowledge that I have received and reviewed this HIPAA privacy notice.

PATIENT OR REPRESENTATIVE SIGNATURE

DATE

PRINTED NAME OF PATIENT OR REPRESENTATIVE

Financial Agreement

This form is required to receive care.

You agree to pay for services.

By receiving care at Diabetes, Thyroid & Hormone Center of the Treasure Coast, you agree to pay for all services provided at the practice's established rates.

You are responsible if insurance does not pay.

If your insurance does not cover a service, pays only part of it or denies a claim, **you are responsible for the remaining balance**. You are also responsible for a **$100 no-show fee** if an appointment is not cancelled at least 48 hours in advance.

Insurance payments can be sent directly to the practice.

You authorize your insurance company (if applicable) to pay benefits directly to the practice. This does **not** remove your responsibility for unpaid amounts.

Collection costs may apply if payment is not made.

If your account is sent to collections or an attorney, you agree to pay reasonable collection costs, including attorney or third-party collection fees.

Not all insurance plans are accepted.

The practice contracts only with certain health plans, and insurers may change a plan's network status without notice to us or to you. If your plan is not on our list, or we are not in network for your plan, **you are responsible for full payment**, even if you have insurance.

You control your health care decisions.

You have the right to make medical decisions and create advance directives (such as a living will or durable power of attorney). If you have one, please provide a copy to the practice.

You consent to being contacted.

You agree that the practice may contact you by phone, text, email or other methods about your care, scheduling, billing or administrative matters. You may revoke this consent **in writing** at any time.

No refunds.

You understand and confirm that there are **no refunds for copayments or any other items sold by this clinic**.

You confirm you understand and agree.

By signing, you confirm that you have read and understand this agreement and that you are authorized to sign for yourself or the patient.

The undersigned confirms that they have read and agree to the terms of this agreement and are authorized to sign.

PATIENT OR REPRESENTATIVE SIGNATURE

DATE

PRINTED NAME OF PATIENT OR REPRESENTATIVE

RELATIONSHIP TO PATIENT (SELF, PARENT, GUARDIAN)

Patient Discharge Policy

Our goal is to provide **safe, effective and respectful care**. In some situations, it may be necessary to end the patient-provider relationship. This policy applies to all patients receiving care at our practice.

Reasons a patient may be discharged

- **Not following the treatment plan**, including:
  - Not taking medications as prescribed
  - Missing appointments
  - Ignoring recommended lifestyle, diet or testing
  - Not reporting side effects or treatment issues
- **Substance abuse** that interferes with treatment or safety
- **Misuse or diversion** of controlled medications
- **Abusive, threatening or disrespectful behavior** toward staff
- **Failure to pay for services**, reviewed case by case
- **Legal action or claims** related to care provided by the practice
- **Actions, statements or reviews** that negatively affect the practice or staff
- **Inactivity for more than one year**, despite reminders to schedule follow-up care
- **Insurance not accepted** and refusal to self-pay
- **Patient request** to transfer or discontinue care
- **Need for a higher level of care** that cannot be safely provided in our clinic

If discharge is necessary

- We will provide **written notice**, following Florida Medical Association (FMA) guidelines
- We will continue to provide care for **up to 30 days**, when appropriate, to allow time to find another provider
- If applicable, a **short-term medication supply** may be provided unless there are safety concerns
- We will offer **referrals to other providers** when possible

Our commitment: We follow Florida medical standards to make sure patients are not abandoned and that transitions of care are handled professionally, safely and respectfully.

I have read and understand the Patient Discharge Policy.

PATIENT OR REPRESENTATIVE SIGNATURE

DATE

PRINTED NAME OF PATIENT OR REPRESENTATIVE

AI Scribe Documentation Consent

Purpose of AI-assisted documentation

During your visit, our clinic may use a **HIPAA-compliant AI assistant**, similar to a medical scribe, to help document and prepare notes for your medical record.

The audio from your visit is used **only to help generate clinical documentation** and is not intended to be shared or stored long term.

AI-assisted documentation helps our health care team create more complete medical records and supports:

- Care communication
- Communication with other health care providers
- Insurance prior authorizations

Questions

If you have questions or concerns about AI-assisted documentation, please speak with a member of our staff **before signing this form**.

Your consent

By continuing with your visit, you acknowledge and consent to the use of AI-assisted documentation as described above. **If you do not want AI-assisted documentation used during your visit**, please tell a member of our staff before your visit begins. Because AI-assisted documentation is part of our clinic workflow, the physician **may determine that the visit cannot proceed** without it.

By signing below, I acknowledge that I have read and understand the information above and consent to the use of AI-assisted documentation during my visit.

PATIENT OR REPRESENTATIVE SIGNATURE

DATE

PRINTED NAME OF PATIENT OR REPRESENTATIVE

Arbitration Agreement

This agreement explains how we will resolve a serious disagreement, if one ever arises, between you and **Diabetes, Thyroid & Hormone Center of the Treasure Coast, LLC** ("Practice"). We believe in open communication and in resolving concerns fairly, respectfully and privately. **Signing this agreement is required to be seen at our practice.** It does not take away your right to raise a concern or bring a claim, or your right to a fair and neutral decision. It simply asks that we work out any dispute outside the courtroom, first through mediation and then, if needed, arbitration. Both are recognized legal processes.

Why we ask every patient to sign: we care deeply about the trust our community places in us. Settling disagreements privately and fairly helps protect our practice's reputation and our providers' licenses, and keeps our time and resources focused on patient care rather than lengthy court cases. Please take your time reading this document and ask us any questions before you sign.

What is arbitration?

Arbitration is a private dispute-resolution process in which a neutral, qualified arbitrator (or panel of arbitrators) hears both sides and makes a binding decision. Arbitration is often faster than court, less formal, more private and less stressful for everyone involved.

1. Mediation first, then arbitration

If a concern cannot be resolved by talking with us directly, both sides will first try **mediation**, where a neutral mediator helps us reach a fair solution together. If mediation does not resolve it, you and the Practice agree that **any dispute or claim related to medical care or treatment**, including claims of medical malpractice, personal injury or wrongful death, will be resolved through **binding arbitration rather than a lawsuit in court**. This agreement applies to future care, past care, and claims involving the Practice and its physicians, staff, contractors and affiliates.

2. Waiver of jury trial

By signing this agreement, **both you and the Practice give up the right to have a judge or jury decide covered disputes in court**. Instead, disputes will be decided by neutral arbitrator(s).

3. Who is bound by this agreement

This agreement applies to you, the patient, your estate, and your legal representatives or heirs. All related claims will be resolved in a single arbitration proceeding whenever possible.

4. Arbitration process (Florida law)

- Arbitration will follow the **Florida Arbitration Code** and applicable Florida medical malpractice laws.
- Arbitrators will be experienced and neutral.
- Arbitration proceedings are **private and confidential**.
- Each side has the right to present evidence and be represented by an attorney.

5. Costs of arbitration

- Each party pays its own attorney fees and case preparation costs.
- Costs of the neutral arbitrator and shared arbitration expenses are divided equally unless otherwise required by law.

6. If a party declines to participate

If one party does not participate after arbitration is properly started, arbitration may proceed as allowed by Florida law, and a binding decision may still be issued.

Arbitration Agreement (continued)

7. Acknowledgment by patient

By signing below, you acknowledge that:

- You understand what arbitration is
- You understand you are giving up the right to a jury trial for covered disputes
- You understand that signing this agreement is required to receive care at this practice
- You have had the chance to read it and ask questions before signing
- All of your questions have been answered

8. Severability

If any part of this agreement is found invalid or unenforceable, the remaining parts will continue in full force.

9. Acceptance

I have read this Arbitration Agreement and agree to its terms.

PATIENT OR REPRESENTATIVE SIGNATURE

DATE

PRINTED NAME OF PATIENT OR REPRESENTATIVE

RELATIONSHIP TO PATIENT (SELF, PARENT, GUARDIAN)

Patient-Provider Partnership Agreement

Please read each section, initial where indicated, and sign at the bottom.

Our commitment to you

At Diabetes, Thyroid & Hormone Center of the Treasure Coast, our physician and nurse practitioners are dedicated to providing expert, personalized, evidence-based care for diabetes, thyroid, hormone, metabolic and weight-related conditions. Safe and effective treatment depends on a strong partnership built on trust, open communication and mutual respect. This agreement explains what you can expect from us and what we ask of you.

1. Trust in your care team

INITIALS _____

I understand that my care at this practice is directed by the physician and nurse practitioners, who have specialized training and experience in endocrinology and metabolic medicine. I agree to trust their clinical judgment, follow the treatment plan we agree on together, and communicate honestly with them about my symptoms, concerns and progress.

2. No self-diagnosis or self-treatment

INITIALS _____

I understand that managing hormone, thyroid, diabetes and metabolic conditions requires lab interpretation, clinical examination and professional judgment. I agree that I will not diagnose or treat myself for the conditions this practice is managing, and I will not make changes to my care plan on my own.

3. Outside research and information

INITIALS _____

I am welcome to learn about my health and bring questions to my visits. However, I understand that information from the internet, social media, podcasts, friends, family or other sources may be inaccurate, incomplete or not appropriate for my situation. I agree that I will not come to conclusions or act on outside information about my condition or treatment without first discussing it with my provider.

4. Medications and supplements

INITIALS _____

I agree that I will not start, stop or change the dose of any medication, hormone, injection, peptide or supplement related to the condition(s) being treated at this practice without first speaking with my provider. This includes prescription and over-the-counter products and supplements purchased elsewhere. I also agree to tell my provider about any new medications or supplements prescribed or recommended by other doctors, so my care team has a complete and accurate list.

Safety exception: If I have a severe or life-threatening reaction (for example, trouble breathing, swelling of the face or throat, chest pain, fainting, or very low blood sugar that does not improve), I will seek emergency care right away by calling **911** or going to the nearest emergency room, and then notify the office as soon as possible.

5. Respectful communication and a positive attitude

INITIALS _____

I agree to treat the physician, nurse practitioners and all staff with courtesy and respect, in person, by phone and through electronic messages. I understand that a positive, cooperative attitude helps my care team serve me and every patient well. I understand that abusive, threatening or disruptive behavior toward staff or other patients may result in dismissal from the practice.

6. Wait times and access to care

INITIALS

I understand that there is a nationwide shortage of endocrinologists and highly trained hormone specialists, and that demand for these services is very high. As a result, delays in appointment availability, waiting room times and responses to phone calls or messages may sometimes occur. I agree to be patient and understanding when this happens. Our team works hard to give every patient the time and attention they need, which can sometimes cause visits to run behind schedule.

7. Concierge care option

INITIALS

I understand that if I prefer shorter wait times, more direct access to my provider, extended visits or a higher level of personalized support, I may ask the front desk about the practice's **concierge care** and membership programs. Participation is optional and is not required to receive care at this practice.

8. My rights as a patient

INITIALS

I understand that this agreement does not limit my right to:

- Ask questions and receive clear explanations about my diagnosis and treatment
- Participate in decisions about my care
- Decline a recommended treatment after discussing the risks and benefits with my provider
- Request a second opinion
- Seek emergency care at any time
- Access my medical records as permitted by law

9. How to reach us

INITIALS

For non-urgent questions about my medications, supplements, symptoms or something I have read or heard, I will contact the office by phone or through the patient portal. My care team will respond as soon as reasonably possible.

For any medical emergency, I will call 911 or go to the nearest emergency room.

Acknowledgment and signature

By signing below, I confirm that I have read and understand this Patient-Provider Partnership Agreement, I have had the chance to ask questions, and I agree to follow it as a patient of Diabetes, Thyroid & Hormone Center of the Treasure Coast. I understand that not following this agreement may affect my safety and the quality of my care and may lead the practice to end our provider-patient relationship.

PATIENT OR REPRESENTATIVE SIGNATURE

DATE

PRINTED NAME OF PATIENT OR REPRESENTATIVE

RELATIONSHIP TO PATIENT (SELF, PARENT, GUARDIAN)