THE SUGAR DOCTORS, LLC
ENDOCRINE • DIABETES • THYROID

Patient Information and Consent

Patient Name

Legal First Name | Legal Last Name | Suffix | Preferred First Name

Today's Visit

What is the reason for your visit today? _____

Have you been treated by Dr Purcell in the past ? ☐ Yes ☐ No

If yes, where ? _____

Patient Demographics

Address | Apt # | City | State | Zip

Cell Phone # | Social Security # | Gender | Birthdate

Language Spoken | Marital Status | Email Address: (we will never rent/sell your email address – we value privacy)

Driver's License # and State | Alternate Phone # | Today's date

Race: ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic ☐ White ☐ Other ☐ Refuse to Disclose

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Refuse to Disclose

Emergency Contact Information

Contact Name | Phone Number | Relationship to Patient

Patient Employment Information

Employer Name | Employer Phone #

Responsible Party Information ☐ Check if patient

Legal Name of Responsible Party | Social Security # | Address

Date of birth | Phone Number | Driver's License # and State

Medical Insurance Information

Insurance Company | Policy Holder's Name | Policy Holder's Relationship to Patient

Policy Holder's Address | City | State | Zip

Policy Holder's Birth Date | Policy Holder's Social Security # | Policy Holder's Employer

Do you have any additional insurance ?: ☐ Yes ☐ No

Insurance Company	Policy Holder's Name	Policy Holder's Relationship to Patient
Policy Holder's Address	City	State Zip
Policy Holder's Birth Date	Policy Holder's Social Security #	Policy Holder's Employer

Insurance Company	Policy Holder's Name	Policy Holder's Relationship to Patient
Policy Holder's Address	City	State Zip
Policy Holder's Birth Date	Policy Holder's Social Security #	Policy Holder's Employer

Patient Consent for Treatment

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by The Sugar Doctors, LLC and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made to the results of the treatments or examinations at The Sugar Doctors, LLC.
2. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with The Sugar Doctors, LLC Notice of Privacy Practices
3. I authorize payment of medical benefits to The Sugar Doctors, LLC physicians or their designee for services rendered.
4. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

_____ _____

Patient or Authorized Person's Signature Date

Workers Compensation Benefits ☐ Applicable ☐ Not Applicable

I hereby authorized The Sugar Doctors, LLC to speak to a rehabilitation specialist, my employer, my insurance carrier or other professionals involved in my care of rehabilitation, regarding my medical records and the treatment I have received or will receive.

_____ _____

Patient or Authorized Person's Signature Date

PERSONAL MEDICAL HISTORY

Note: This is a confidential report of your medical history
Information contained here will be released only if you have authorized us to do so

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Pharmacy: _____ Pharmacy Phone #: _____

Pharmacy Address: _____ DOB: _____/_____/_____

Primary Care Physician: _____ Referring Physician: _____

Past Medical History:

Check any conditions you have had:

- ☐ Abnormal EKG
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Asthma
- ☐ Bone Disease
- ☐ Breast Lump
- ☐ Cancer
  Type: _____
- ☐ Coronary Artery Disease (Heart Disease)
- ☐ Decreased Libido
- ☐ Depression
- ☐ Pre-Diabetes
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Dyslipidemia (High Cholesterol)
- ☐ Emphysema
- ☐ Endocrine Disorder
- ☐ Gallbladder Disease
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ Hypertension (High Blood Pressure)
- ☐ Hyperthyroidism (overactive thyroid)
- ☐ Hyperthyroid (underactive thyroid)
- ☐ Impotence/ED
- ☐ Infertility
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Meningitis
- ☐ Mental Illness
- ☐ Migraines
- ☐ Nipple Discharge
- ☐ Heart Murmur
- ☐ Osteoporosis
- ☐ Phlebitis
- ☐ Postmenopausal Bleeding
- ☐ Seizures
- ☐ Serious Injury
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Thyroid Cancer
- ☐ Thyroid Nodule
- ☐ Tuberculosis

Have you ever had External Beam Neck Radiation ?
☐ No ☐ Yes Date: _____

Other major disease: _____

_____

Health Maintenance: (Fill in all that apply)

Date/Place of last Eye Exam: _____
Date/Place of last Prostate Exam: _____
Date/Place of last PAP test: _____
Date/Place of last Mammogram: _____
Date/Place of last Bone Density: _____
Date/Place of last EKG: _____
Date/Place of last Stress Test: _____
Date/Place of last Colonoscopy: _____

Past Surgical History:

Have you ever had surgery ? ☐ Yes ☐ No

If yes, please list:

Type: _____ Year: _____
Type: _____ Year: _____
Type: _____ Year: _____
Type: _____ Year: _____

Recent Hospitalizations: _____

_____

_____

_____

Medications:

List all medicines and supplements you take:

Medication or Supplement	How much ?	How often ?

Have you had Diabetes Education in the last year ? ☐ Yes ☐ No

Allergies:

Are you allergic to any medications ? ☐ Yes ☐ No

Please list: _____

_____

Are you allergic to latex ? ☐ Yes ☐ No

Are you allergic to any foods ? ☐ Yes ☐ No

Please list: _____

_____

Family History: Parents, Grandparents, Brothers, Sisters, Children, Aunts and Uncles

YES	NO	Disease:	Relative(s):
☐	☐	Asthma	
☐	☐	Cancer	
☐	☐	Diabetes	
☐	☐	Heart Disease	
☐	☐	High Blood Pressure	
☐	☐	Kidney Disease	
☐	☐	Mental Illness	
☐	☐	Other glandular Disease	
☐	☐	Stomach Ulcers	
☐	☐	Stroke	
☐	☐	Thyroid Disease / Goiter	
☐	☐	Tuberculosis	

Social History:

Do you use alcohol ?

☐ Never ☐ Former ☐ Some Days ☐ Everyday

Do you drink caffeinated beverages ?

☐ Yes ☐ No

Have you ever smoked ?

☐ Never ☐ Former ☐ Some Days ☐ Everyday

If yes, how many years have you smoked ? _____

Packs per day ? _____

How often do you exercise ?

☐ Never ☐ 1X per wk ☐ 2-3X per week ☐ 4+X per week

Are your parents living ? ☐ Mom ☐ Dad

How many siblings do you have ? _____

How many children do you have ? _____

Your highest level of education ? _____

Occupation: _____

Symptoms: *Please check the appropriate boxes indicating the symptoms you have had within the last year*

CONSTITUTIONAL
- ☐ Change in weight of more than 10 pounds
- ☐ Night Sweats
- ☐ Fatigue

EYES
- ☐ Trouble with Vision
- ☐ Changes in Vision
- ☐ Double Vision
- ☐ Blurred Vision

HEAD ENT
- ☐ Changes in Hearing
- ☐ Hoarseness
- ☐ Headaches

BREASTS
- ☐ Changes in Skin
- ☐ Masses
- ☐ Nipple Discharge

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression

CARLDIOVASCULAR
- ☐ Palpitations
- ☐ Chest Pain
- ☐ Difficulty Breathing on Exertion
- ☐ Lower Extremity Swelling
- ☐ Loss of Consciousness

RESPIRATORY
- ☐ Chronic Cough
- ☐ Coughing Blood
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Difficulty Breathing

GASTROINTESTINAL
- ☐ Difficulty Swallowing
- ☐ Reflux
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in Stools
- ☐ Changes in Bowel Habits

GENITOURINARY
- ☐ Painful or Difficult Urination
- ☐ Excessive Urination at Night
- ☐ Post Void Dribbling
- ☐ Blood in Urine
- ☐ Urgency

INTEGUMENT/SKIN
- ☐ Pigmentation Changes
- ☐ Skin Dryness
- ☐ Rash
- ☐ New Skin Lesion
- ☐ Changes to Existing Skin Lesions/Moles
- ☐ Hair Growth Change

NEUROLOGIC
- ☐ Tremors
- ☐ Speech Difficulties
- ☐ Paralysis
- ☐ Tingling or Numbness
- ☐ Seizures
- ☐ Muscular Weakness

MUSCULOSKELETAL
- ☐ Muscle Cramps
- ☐ Nocturnal Leg Cramps
- ☐ Joint Pain
- ☐ Joint Swelling

ENDOCRINE
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Drinking More Fluids
- ☐ Excessive Urination
- ☐ Excessive/Abnormal Thirst
- ☐ Excessive Hair Growth
- ☐ Hot Flashes

HEMA-LYMPH
- ☐ Lymph Node Enlargement
- ☐ Easy Bleeding
- ☐ Easy Bruising

ALLERGIC-IMMUNO
- ☐ Sinus Allergy
- ☐ Hay Fever
- ☐ Allergic Dermatitis

I certify that the two pages of my Personal History to be accurate and current to the best of my knowledge

Patient Signature: _____ Date: _____

Financial Policy and Disclosure

The Financial Policy and Disclosure is to help us provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients

Patients are responsible for the payment of all services provided by The Sugar Doctors, LLC .

Self-Pay Policy

- If you are a self-pay patient, you will be required to pay for the office visit before services are rendered
- In addition, any remaining balance on your account will be collected at discharge

Insurance Policy

- If you are an insurance patient, it is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information
- If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service.
- If we have not received a payment from your insurance company within thirty (30) days of filing, you will be responsible for the balance due
- Deductibles, co-payments, and co-insurance will be collected before services are rendered.
- In special cases, we may need your help in contacting your insurance company for the payment of your services
- POS/HMO; It is the responsibility of the patient to obtain prior authorization from your primary care physician before each visit to our office. Patients will be responsible for an unpaid balance due if prior authorization is not done.

Worker's Compensation Policy

- If you are a worker's compensation patient, it is our policy to bill your employer or the worker's compensation carrier for services rendered
- If you are covered under worker's compensation, we will accept the payments by the worker's compensation carrier as per contracted rates based on the mandated FL state fee schedule
- If payment is denied from your worker's compensation carrier, you will become responsible for the entire balance of your services. Payment will be due within ten (10) days following any worker's compensation payment denial.
- It will be your responsibility to contact us with the name and address of your employer or the insurance company that covers your employer.

Overdue and Credit Balances

- All over-due patient balances will be sent to collections
- All accounts sent to collections will be charged a $25 collection fee in addition to the account balance.
- Credit balances under $15 aged over sixty (60) days may be written off

Divorce or Custody Case Policy

- The parent or guardian who brings the patient into our office will be held financially responsible, regardless of the provisions in the divorce decree, or who has custody, or who has insurance

To help in this policy, we ask that you assist us by:

1. Providing us with the current and updated information on yourself and your insurance company
2. Presenting an updated photo identification card and insurance card when changes are made.
3. Making the appropriate payment at the time of service, whether it is a deductible, copay, coinsurance, or for the full amount if you are a self-pay patient.

In order to provide the best medical care, we ask that you do not discuss your account balance or financial aspects with the physician(s) or medical staff. Please discuss any account information with the check-out associate or front desk

_____ _____

Responsible Party's Signature **Date**

THE SUGAR DOCTORS, LLC
ENDOCRINE • DIABETES • THYROID

Patient Acknowledgement

Appointment Cancellation Policy

The Sugar Doctors, LLC has instituted an Appointment Cancellation Policy. A cancellation made with less than a 24-hr notice significantly limits our ability to make the appointment available to another patient in need.

1. Please provide our office with a 24-hr notice in the event that you need to reschedule your appointment. This will allow us the opportunity to provide care to another patient. A message can always be left with the answering service to avoid a cancellation fee being charged.
2. A "No-Show", "No-Call" or missed appointment, without proper 24-hr notification, may be assessed a $25 fee.
3. This fee is not billable to your insurance.
4. If you are 15 or more minutes late for your appointment, the appointment may be cancelled and rescheduled
5. As a courtesy, we make reminder calls or text messages, for appointments, one to two days in advance. Please note that if a reminder call, text or message is not received, the cancellation policy remains in effect.
6. Repeated missed appointments may result in termination of the physician/patient relationship. If you have any questions regarding this policy, please let our staff know and we will be happy to clarify any questions you may have. A copy of this policy will be provided to you. Please sign and date below your acknowledgement.

I have read and understand the Appointment Cancellation Policy and I acknowledge it's terms. I also understand and agree that such terms may be amended from time-to-time by the clinic.

Signature: _____

Printed Name: _____

Date: _____

Important Information About Patient Email

PLEASE READ THIS INFORMATION CAREFULLY

As a patient of The Sugar Doctors, LLC, you may request that we communicate with you by electronic mail (email). This Fact Sheet will inform you about the risks of communicating with your health care provider via email and how The Sugar Doctors, LLC will use you and disclose provider / patient email.

Email communications are two-way communications. However, responses and replies to emails sent or received by either you or your health care provider may be hours or days apart. This means that there could be a delay in receiving treatment for an acute condition.

If you have an urgent or an emergency situation, you should not rely solely on provider/patient email to request assistance or to describe the urgent or emergency situation. Instead, you should act as though provider/patient email is not available to you and seek medical attention.

Email messages on your computer, laptop or other device have inherent privacy risks especially when your email access is provided through your employer or when access to your email messages is not encrypted (protected).

Unencrypted email provides as much privacy as a postcard. You should not communicate any information with your health care provider that you would not want to be included on a postcard that is sent through the Post Office.

Email is sent at the touch of a button. Once sent, an email message cannot be recalled or cancelled. Errors in transmission can occur. You can also help minimize this risk by using only the email address that you provide to The Sugar Doctors, LLC.

In order to forward or to process and respond to your email, individuals at The Sugar Doctors, LLC other than your health care provider may read your email message. Your email message is not a private communication between you and your treating provider.

At your health care provider's discretion, your email message and any or all responses may become part of your permanent medical record.

The Sugar Doctors, LLC encourages patients to use the patient portal to communicate with healthcare providers directly via email.

Alternatively, patients may receive secure (encrypted) email from their health care provider. These messages require patients to establish an account to receive messages from providers.

Finally, patients have the right to request to communicate directly with their healthcare provider without encrypting communications.

_____ _____

Signature of Patient or Person Representative Date

HIPAA Information and Consent Form

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services.

The Sugar Doctors, LLC has adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I acknowledge that I have had the opportunity to review a copy of The Sugar Doctors, LLC's Notice of Privacy Practices. I understand that I am responsible to read the Notice of Privacy Practices and notify The Sugar Doctors, LLC, in writing, of any for restrictions in the use of my Private Health Information (PHI). I understand The Sugar Doctors, LLC has the right to revise the Notice of Privacy Practices at any time and will post the current copy on their website www.thesugardoctors.com. I understand I have a right to request and receive a copy upon request.

I, _____date_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Consent for Medical Information Release

There are times we are asked to give family members or others information regarding you and your treatment. If you would like for us to give out information, please fill in the name of the individual and their relationship to you.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____