MyEndoHealth
Diabetes and Wellness Center

MARCO FIORE URIZAR, MD
RAMÓN E. MARTINEZ, MD
BOARD CERTIFIED INTERNAL MEDICINE,
ENDOCRINOLOGY, DIABETES AND METABOLISM
1 SW 129th Ave. Suite 105. Pembroke Pines. Fl. 33027
Phone: 954 368 9141- Fax: 954 451 0836

PATIENT INFORMATION

Name: _____ Sex: _____

Cell Phone: _____ Home Phone: _____

Address: _____ City/State/Zip: _____

Date Of Birth (Month/Day/Year): _____ Social Security Number (last 4 digits) _____

Email: _____

Emergency contact

Name: _____ Phone: _____ Relationship: _____

PRIMARY CARE/ REFERRING PHYSICIAN INFORMATION

PCP Name: _____ Phone: _____ Fax: _____

REFERRING Physician Name: _____ Phone: _____ Fax: _____

INSURANCE COMPANY INFORMATION:

Name of Primary Insurance Company: _____ Policy Number: _____ Group Number: _____

Name of Secondary Insurance Company: _____ Policy Number: _____ Group Number: _____

PHARMACY INFORMATION

Name: _____ Phone: _____

Address: _____ City/State/Zip: _____

AUTHORIZING FAMILY/FRIEND

- We cannot communicate any information to any other person than you.
- Please Inform in this document if you wish to add anyone in your list that can be authorized to call on your behalf (including spouse):

NAME: _____

RELATIONSHIP: _____

PHONE NUMBER: _____

MyEndoHealth
Diabetes and Wellness Center

MARCO FIORE URIZAR, MD
RAMÓN E. MARTINEZ, MD
BOARD CERTIFIED INTERNAL MEDICINE,
ENDOCRINOLOGY, DIABETES AND METABOLISM
1 SW 129th Ave. Suite 105. Pembroke Pines. Fl. 33027
Phone: 954 368 9141- Fax: 954 451 0836

OFFICE POLICIES AND PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing MY ENDO HEALTH. We are pleased to participate in your health care and look forward to establishing a lasting relationship. As your endocrinologist, I will follow all your endocrine conditions. Any other concerns outside of my scope of expertise would have to be addressed with your primary care physician. As part of this relationship, we have outlined our expectations. Please review and sign this form to acknowledge your understanding of our patient financial and office policies:

INSURANCE:

- Because of the increase of new plans with each insurance; when you request your appointment, you are required to provide the exact information show on both your insurance card and ID, in order to verify that we are currently **IN-NETWORK** with your Insurance and your Plan. Please send a picture of your Insurance Cards and ID to *info@myendo-health.com*
- At the time of service, you must present your Insurance Card and ID to verify the information is updated in our system.
- It is your responsibility to contact your insurance regarding your coverage, policy provisions, exclusions and limitations, as well as the authorization requirements (Primary Physician).
- Patients without insurance (or inactive insurance) are considered payments on their own and must pay in full at the time of service. Our self-pay rates are very reasonable and less expensive than the community average.
- If your plan has a new group number, we must have the information to process your claims correctly.

IDENTITY VERIFICATION:

- As part of the Identity verification, we will request your ID and your Medical Insurance Card.
- If there is any difference with your ID, you have to contact your insurance carrier to update it. Once the information is corrected we will proceed with your appointment.
- If your last name is in the process of being changed. We will verify your name, last 4 digits of your Social Security and Date of Birth.
- If you don't have SSN, you must provide a legal verifiable documentation of any name change to save to the file (like a marriage certificate if the name change is due to marriage).

CO-PAYS, DEDUCTIBLES & BALANCES:

- *As a courtesy to you*, we contact your insurance company to verify your benefits, and also bill your insurance for services.
- Any amounts given to us by the time of your service are only quotes and not a guarantee of payment. This estimate amount (copay, deductible or co-insurance) is due at the time of the service, until the insurance determines what the exact amount will be.
- Supplemental Coverage: We verify coverage with the primary insurance only, which must be in network. We collect any responsibility based on the primary insurance. The claim is sent for the service rendered to both the primary and any secondary insurances. Coordination of benefits must be up to date with your insurance carrier per their policy.
- If after processing the claim, your insurance determine a different amount, ultimately, you will be responsible for the payment of any treatment and / or any additional charge. If the account reflects any overpayment, the amount will be credited to the next follow up appointment. Unless, you contact the office to request a refund by check before your next visit. For patients with no follow visits, refunds are processed manually every 6 months.
- The deductible is determined by the contract with your insurance carrier.
- If your insurance coverage terminates for any reason, you are responsible for the total claim amount.
- Any pending balance should be paid at the time of service. If you have a financial concern, please notify our office and we will try to assist with a payment plan option.
- Rendered service: All payments made for healthcare treatment rendered to the patient are non-refundable.

REFERRALS:

- Please be aware you are responsible to provide any referral or prior authorization from your primary care doctor. If you are not able to get the referral on time, we will need to reschedule your appointment.
- If your plan requires authorizations for treatment, new authorization will be needed if and when your plan changes.
- If the referral is rejected by your insurance, you are responsible for the payment of the medical visit and you have to verify the reason with the insurance and with the office that provided the referral.

MEDICARE PATIENTS:

- If you have Medicare and do not have secondary coverage, you will be expected to pay your portion of the cost of your treatment at the time of service. (Deductible or Co-Insurance when applicable)
- If you have Medicare and Secondary Insurance coverage, we will wait until all secondary insurers have paid on your claim before we bill you for the remaining balance.

BILLING & STATEMENTS:

- Patient statements are mailed out monthly. You are responsible for making a payment or arranging a payment plan with our office, and failure to pay will result in additional late fees and ultimately collection actions being implemented to collect the debt.

MyEndoHealth
Diabetes and Wellness Center

MARCO FIORE URIZAR, MD
RAMÓN E. MARTINEZ, MD
BOARD CERTIFIED INTERNAL MEDICINE,
ENDOCRINOLOGY, DIABETES AND METABOLISM
1 SW 129th Ave. Suite 105. Pembroke Pines. Fl. 33027
Phone: 954 368 9141- Fax: 954 451 0836

ADMINISTRATIVE FEES:

- Returned checks are subject to a $35 charge. We will accept payment only by cash or credit card until the balance is cleared.
- Completing forms or creating a letter on your behalf fee is $15. (Patient Assistance Program Application, Disability form, etc) Most forms require 5 to 7 business days to research your information and complete forms. Please note that Dr. Fiore can only complete forms pertaining to an endocrine concern, any other forms should be addressed to your primary care.
- Medical records fees: Processing time for retrieving medical records is a courtesy from our office.

Sending by email or by fax has no cost to you. When picking up from office in a printed format we charge $1.00 per page for the first 25 pages and .25 cents for every additional page for overhead associated for printing records. (Florida Rule 64B8-10.003)

MEDICATION REFILLS:

- If you have not been seen in the office for over 6 months, please schedule an appointment and we will only provide refills until your scheduled appointment.
- We cannot be responsible for any interruptions in medications for patients whom have not been seen in the office over a year.
- We have 72 hours response for medication refill request with no call backs.

PHARMACY COVERAGE:

- The greatest challenge to our practice is to be able to prescribe medications that are covered under your insurance plan.
- Please take note that Dr. Fiore will first submit the medication that he feels is the most appropriate for your condition.
- In the event that your insurance does not cover what Dr. Fiore has prescribed, we will try our best to find a substitute.
- Please do understand that a prior authorization for a medication is not a phone call away as some insurers imply, but requires medical notes, multiple forms to be faxed, and much more.
- If it's a simple change and we can find an alternative equivalent medication, we will make the changes.
- If we do need to appeal for a prior authorization which will require a written explanation and prolonged time on phone and faxing, **please allow at least a 2 to 4 weeks before you expect to hear from us** as the insurance responses are often by mail.

LABS ORDERS:

- The Doctor will provide you a printed order for the laboratory or we will send it out to your email. It will not be sent directly to the laboratory. Please remember to take a printed version with you to the laboratory of your choice.

LABS RESULT:

- Results are not evaluated or communicated by mid-level staff, because a normal result does not promise health and abnormal result does not mean you are sick.
- Only the Doctor will review, interpret and draw a conclusion of results of labs and/ or imaging he has prescribed on a follow up visit .
- My Endo Health will not accept financial responsibility for any test submitted to the laboratory, if your insurance company does not cover the submitted claim, you will be responsible for payment to the laboratory.

OFFICE COMMUNICATION

- We will gladly address your requests or inquiries to our office. Please remember our patient care center can only follow up on non-emergency requests. Telephone calls, texts or emails received will be answered in the order in which they were received in the next 24-48 hours.

CONSENT TO MAIL, CALL, TEXT OR E-MAIL:

- **In the case of any emergency please call 911 or proceed to the nearest Emergency Room. Do not use this way of communication for that purpose.**
- This form is used to obtain your consent to communicate with you by mail, email, calls , mobile text messaging regarding your Protected Health Information; neccesary for your effective treatment and to ensure a smooth and uninterrupted communication with our office. No marketing or promotional material will be sent. MY ENDO HEALTH, (MEH) offers patients the opportunity to communicate by email/mobile text messaging. MEH will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, MEH cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between MEH and me and consent to the conditions outlined herein. Any questions I may had were answered.
- I hereby authorize My Endo Health, LLC representative or my physician to mail, call, text or email me with communications regarding my healthcare, including but not limited to such things as appointments reminders, referral arrangements and laboratory results.

I have read ALL of the above terms and conditions. I authorize the release of any medical or other information necessary to process my claims. I authorize payment of medical benefits to Dr. Marco Fiore, MD or supplier for services rendered. , I understand that regardless of any insurance coverage that I may have, I am responsible for payment on my account not covered by my insurance. By signing below, I acknowledge I have received, understand and will comply with the policies and procedures explained in our office.

Signature of Patient: _____ Print name: _____ Date: _____

MyEndoHealth
Diabetes and Wellness Center

MARCO FIORE URIZAR, MD
RAMÓN E. MARTINEZ, MD
BOARD CERTIFIED INTERNAL MEDICINE,
ENDOCRINOLOGY, DIABETES AND METABOLISM
1 SW 129th Ave. Suite 105. Pembroke Pines. Fl. 33027
Phone: 954 368 9141- Fax: 954 451 0836

LATE CANCELLATION, NO CONFIRMATION, NO SHOW POLICY.

We understand that situations arise in which you must cancel your appointment. It is therefore your responsibility to cancel your appointment. You need to provide a notice, the latest **2 business days prior to the visit. The Doctor reserved his time for you that day. Each time a patient misses an appointment, another patient is prevented from receiving care. Therefore, if no confirmation; MY ENDO HEALTH reserves the right to cancel your appointment by 2:00pm the day prior to your visit. If there is a same-day cancellation or a 'no-show' after confirmation, a fee of $40 will apply for office visits and $70 for ultrasound visits.**

This fee is not covered by insurance and must be paid prior to your next appointment.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

.....
Signature

.....
Name

.....
Date:

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) and ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with **MY ENDO HEALTH**., "Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

Patient's Signature: _____ Name: _____

Date: _____

*May be requested to show proof of representative status.

MyEndoHealth
Diabetes and Wellness Center

MARCO FIORE URIZAR, MD
RAMÓN E. MARTINEZ, MD
BOARD CERTIFIED INTERNAL MEDICINE,
ENDOCRINOLOGY, DIABETES AND METABOLISM
1 SW 129th Ave. Suite 105. Pembroke Pines. Fl. 33027
Phone: 954 368 9141- Fax: 954 451 0836

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Patient Name: _____ SS# (last 4 digits) _____

Telephone #: _____ Date of Birth: (M/D/Y) _____/_____/_____

Address: _____

I authorize MY ENDO HEALTH., to release the health information indicated below to:

Person/ Organization: _____
Check a Box

- ☐ By FAX #:_____
- ☐ Pick-up from Office : Located at: 1 SW 129th Ave. Suite.105. Pembroke Pines. Fl. 33027.
- ☐ By E-mail: for the purpose of alternative means of confidential communication the use of the following:

Email Address: _____

MY ENDO HEALTH., (MEH) offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. MEH will use reasonable means to protect the security and confidentiality of email information sent and received. However, MEH cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication via email and I consent to the conditions outlined herein. Any questions I may have had were answered.

Dates of Medical Record Release: _____
Reason for Disclosure: Check a Box ☑

☐ Continuing Care ☐ Insurance ☐ Legal ☐ Personal Use ☐ Other Reason

Check a Box ☑

☐	Complete Record	☐	Radiology Reports
☐	Lab Reports	☐	Pathology Reports
☐	Operational Reports	☐	Other (Specify)

SPECIFIC AUTHORIZATIONS

The Following Information will not be released unless you specifically authorize it by marking the relevant box(es) below:

☐ Drug/ Alcohol Abuse or Treatment ☐ HIV/ AIDS Test Results or diagnoses ☐ Genetic Testing Information
☐ Psychotherapy Notes (The release of Psychotherapy Notes required a separate authorization)

This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authorization and consent will expire one year from the date of authorization written below. Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the Recipient may no longer be protected by law.

_____ Date Signed: _____/_____/_____
Signature of Patient or Legal Representative

Printed Name: _____ Relationship if not Patient: _____

**If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care). **For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18. A court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of the estate.

MyEndoHealth
Diabetes and Wellness Center

MARCO FIORE URIZAR, MD
RAMÓN E. MARTINEZ, MD
BOARD CERTIFIED INTERNAL MEDICINE,
ENDOCRINOLOGY, DIABETES AND METABOLISM
1 SW 129th Ave. Suite 105. Pembroke Pines. Fl. 33027
Phone: 954 368 9141- Fax: 954 451 0836

MEDICAL HISTORY FORM - PLEASE COMPLETE ALL INFORMATION

NAME: _____

MEDICAL PROBLEMS (heart disease, high blood pressure, diabetes, etc) & date of diagnosis.

_____

_____

_____

PRIOR SURGERIES (with dates)

_____

_____

_____

PRIOR HOSPITALIZATIONS (with dates)

_____

_____

_____

FAMILY HISTORY

Father - Alive? _____ Medical conditions _____

Mother - Alive?_____ Medical conditions _____

Siblings How many?_____ Medical conditions _____

Children - How many?____ Medical conditions_____

SOCIAL HISTORY:

Do you currently use tobacco? _____ If yes, how much per day? _____

Have you ever used tobacco? _____ Did you quit? If yes, when? _____

Do you drink alcohol? _____ If yes, what type of alcohol? Beer, Wine,Cocktails _____

How many drinks/day? _____

MyEndoHealth
Diabetes and Wellness Center

MARCO FIORE URIZAR, MD
RAMÓN E. MARTINEZ, MD
BOARD CERTIFIED INTERNAL MEDICINE,
ENDOCRINOLOGY, DIABETES AND METABOLISM
1 SW 129th Ave. Suite 105. Pembroke Pines. Fl. 33027
Phone: 954 368 9141- Fax: 954 451 0836

ALLERGIES

Do you have any medication allergies? _____

If yes, list medications and the reactions? (nausea, vomiting, rash, trouble breathing)

_____

_____

_____

MEDICATIONS: (Please list all medications you are presently taking including vitamins. minerals. and supplements)

Medication Name	Strength	How often?