PATIENT FINANCIAL RESPONSIBILITY CONSENT FORM

Patient Name:	Date of Birth: MM/DD/YYYY ____ / ____ / _____

The patient (or parent/guarantor) is ultimately responsible for the payment for treatment and care. We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.

Patients are responsible for payment of co-pays, co-insurance, deductibles, service charges, and all other procedures or treatments not covered by their insurance plan. Co-pays are due at the time of service. Co-insurance, deductibles and non-covered items are due 30 days from receipt of billing.

Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:

Service / Charge	Patient/Guarantor Fee
No show appointment	$50.00 per visit
After-hours prescriptions	$35.00 per prescription
After-hours Non-emergency call	$30.00 per call
Returned check	$30.00 per check
Medical Records	$1.00 per page for the first 25 pages; $0.25 for each page in excess of 25 pages

We respect patient confidentiality and PEMC of Florida, LLC will only release personal health information about you in accordance with the State and federal law. I hereby authorize Pediatric Endocrine and Metabolic Center of Florida (PEMC of Florida, LLC) to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.

PATIENT/PARENT/GUARANTOR:

Name:	Relation:
Signature:	Date:

VOICE, TEXT MESSAGING AND EMAIL COMMUNICATION CONSENT FORM

Patient Name:	Date of Birth: MM/DD/YYYY ____ / ____ / _____

In an effort to relay medical and non-medical information to our patients we have implemented new electronic communication methods via our Electronic Medical Records system.

I understand that in order for PEMC of Florida, LLC to leave detailed messages containing specific medical information on my voicemail or answering machine, I need to give my permission to PEMC of Florida, LLC.

I further understand that in order for PEMC of Florida, LLC to text detailed messages containing non-medical information to my cell phone I need to give my written express permission to PEMC of Florida, LLC.

I also understand that my healthcare information at PEMC of Florida, LLC is protected, and a copy of the Notice of Privacy Practices is available upon my request.

Consent for Voice Messages

I give my written express consent to PEMC of Florida, LLC to leave detailed messages on my voicemail/answering machine about my NORMAL lab results, diagnostic and/or imaging results, prescription information, or appointment reminders. No abnormal results will be communicated via our automated system.

Consent for Text Messages

I give my written express consent to PEMC of Florida, LLC to leave appointment confirmation text messages to my cellphone.

Consent for Email Messages

I give my written express consent to PEMC of Florida, LLC to leave appointment confirmation and non-medical communications to my email address.

It is my responsibility to keep this information up to date, as I recognize that my information may change over time. This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that I must provide written notice in order to revoke this consent.

Cell #: _____ (will be used for voice and text messaging)

Email: _____ (will be used for appointment reminders)

PATIENT/PARENT/GUARANTOR:

Name:	Relation:
Signature:	Date:

COMPREHENSIVE PELVIC EXAMINATION CONSENT FORM

Patient Name:	Date of Birth: MM/DD/YYYY ____ / ____ / _____

Beginning July 1st, 2020, the State of Florida signed into a law (SB 698) a requirement that individuals must consent in writing to a pelvic examination, which includes the external genitalia or rectal areas, prior to being examined.

It appears this law was intended to prevent individuals from inappropriate examinations while sedated, however, the language of the law is interpretated as it is applicable for all physical comprehensive examinations of the pelvic area.

Although the law is not clear whether a visual examination is included or not, we are asking all patients and/or parents and/or guarantor and/or guardian and/or legal representatives to sign this consent for examination.

EXAMINATION CONSENT

☐ I consent to a medically indicated physical examination which may include but may not be limited to an examination of external genitalia or pelvic area. This examination will be performed by any qualified provider from PEMC of Florida, LLC.

☐ I DO NOT consent to a medically indicated physical examination which may include but may not be limited to an examination of external genitalia or pelvic area.

This consent will remain active until I withdraw my consent in writing.

PATIENT/PARENT/GUARANTOR:

Name:	Relation:
Signature:	Date:

MEDICAL RECORDS REQUEST/RELEASE CONSENT FORM

PATIENT INFORMATION

Patient Name:	Request Date: MM/DD/YYYY ____ / ____ / _____
Street Address:	Date of Birth: MM/DD/YYYY ____ / ____ / _____
City, State, Zip Code:	Phone:

PRACTICE INFORMATION

Pediatric Endocrine and Metabolic Center of Florida PEMC of Florida, LLC	**Dr. Miladys M. Palau Collazo** Pediatric Endocrinologist
9401 SW Discovery Way, Ste 102 Port St. Lucie, FL 34987	Phone: (772) 834-7362 Fax: **(772) 618-2024**

☐ To REQUEST information FROM OR ☐ To RELEASE information TO

Practice Name:	Phone:
Physician Name:	Fax:

AUTHORIZATION

Please Indicate the purpose of this authorization: *(mark all that applies)*

☐ Further Medical Care ☐ Changing Physicians	☐ Personal ☐ Research Related Treatment	☐ Legal Investigation or Action ☐ Disclosure to a third party ☐ Other: _____

I authorize the release of the following Protected Health Information: *(mark all that applies)*

☐ Entire Record ☐ Last Visit Record ☐ Medical History, Examinations, Reports	☐ Laboratory Orders ☐ X-Ray Reports ☐ Surgical Reports ☐ Hospital Records and Reports	☐ Prescriptions ☐ Treatments or Tests ☐ MR/DD Reports ☐ Other: _____

I hereby authorize the use of disclosure of my individually identifiable health information as described. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment, or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. Therefore, I release PEMC of Florida, LLC from all liability arising from this disclosure of my health information. BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

PATIENT/PARENT/GUARANTOR:

Name:	Relation:
Signature:	Date:

TELEMEDICINE CONSULTATION CONSENT FORM

Patient Name:	Date of Birth: MM/DD/YYYY ____ / ____ / _____

I authorize Pediatric Endocrine and Metabolic Center of Florida (PEMC of Florida, LLC), contracted providers to provide me with their observations and recommendations regarding my medical condition and potential courses of action, using telemedicine.

The use of telemedicine involves the electronic communication of my medical information. I understand that the provider will not perform an in-person physical examination during the telemedicine consult. They will rely solely on the information telecommunicated.

I understand that the telemedicine visit will be done through a two-way video link-up. The healthcare provider will be able to see my image on the screen and hear my voice. I will be able to hear and see the healthcare provider.

I understand that the laws that protect privacy and the confidentiality of medical information including (HIPPA) also apply to telemedicine.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

I understand that there are risks from telemedicine, including but not limited to: loss of records from failure of electronic equipment; power failure with loss of communication; and invasion of electronic records from outsiders (hackers). In addition, signs and symptoms that might be detected during an in-person physical examination may not be detected through telemedicine. I understand that I had the option of seeing the physician on a face-to-face basis but opted for a telehealth appointment during COVID-19 pandemic.

I warrant that the provider/physician observations and recommendations are limited in scope and nature to the specific issues discussed during the telemedicine consult.

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 effecting my right to future care or treatment.

I understand that by signing this form that I am consenting to receive health care services via telemedicine.

Cell #: _____ Email: _____

PATIENT/PARENT/GUARANTOR:

Name:	Relation:
Signature:	Date: