FLORIDA DIABETES & ENDOCRINE ASSOCIATES

CONSENT FOR TREATMENT/PAYMENT/HEALTH CARE OPERATIONS, HIPAA NOTICE OF PRIVACY PRACTICES, OFFICE POLICY FORMS

I acknowledge that I have read the above forms at Florida Diabetes and Endocrine Associates' website DOCENDOMD.COM or in the office and I understand and agree to the policies given to me. I also understand that a written copy of the above policies will be given to me upon my request if I am unable to access the policy forms online.

Patient/Guardian Signature_____

Patient Name_____ DATE_____

Guardian Name_____

Employee Signature_____

Employee Name_____DATE_____

Please visit our website at DOCENDOMD.COM

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