



**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 _____

*By signing below, I agree to receive email/text messages of appointments and health care reminders:

Patient Signature _____

Employee Signature _____

Employee Name _____ DATE _____

Please visit our website at DOCENDOMD.COM