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 Name *

First Name Last Name

Date *

Month Day Year

Guardian Name

First Name Last Name

Please sign/check below if you would like to receive text/email message reminders for upcoming appointments and health care considerations: *

- ☐ I agree to receive Text Messages for the above
- ☐ I agree to receive Email Messages for the above
- ☐ I do not wish to receive Text nor Email messages for the above

Patient Name *

First Name Last Name

Date *

Month Day Year

Guardian Name

First Name Last Name

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