PLEASE INITIAL EVERY LINE AND SIGN AT THE BOTTOM

The regulations below MUST be agreed on prior to being seen by a provider, if there is a regulation that you do not agree with, we unfortunately will not be able to proceed with seeing you.

We thank you very much for choosing our office. It is a great privilege to be able to serve you and to take part of your health care needs. We will always strive to meet your expectations and to provide you with the best medical care possible.

Please carefully review and initial the following rules and regulations related to our office. Please always try to follow these regulations as they are intended to make the work flow in our office more efficient and practical. If you have any questions about these rules, please do not hesitate to ask one of our office staff members.

_____ 1) During your visit you will be seen by any of our providers depending on who is available. Due to the type of care we provide, a provider can be called to cover the hospital patients and may not be available. You may be seen by a different covering provider. All of our providers are licensed and highly qualified. You have a team of providers taking care of you , not just one person.

_____ 2) If you have been waiting in the waiting area and not called into an exam room for more than 30 minutes, please alert the front desk immediately. Our goal is to cut down your wait in the lobby as much as possible.

_____ 3) Copays, deductibles and coinsurances are expected to be paid fully at the visit.

_____ 4) Please get all of your prescriptions during your office visit. Please make sure the prescription that you receive will last until your next appointment.

_____ 5) If you need prescription refills, in between office visits please contact your pharmacy and ask them to send us an electronic refill request. The pharmacy may take several days for them to contact us. Please allow one week for this to be completed.

_____ 6) We do not provide any results over the phone due to HIPAA laws. Please do not call asking for results those will be discussed with you during your next office visit.

_____ 7) Please note that the labs and other results such as radiological studies are reviewed only during an office visit. Anytime you have test completed; please make sure you have an appointment to go over the results. If you for some reason do not show up for an appointment and have abnormal results, it will not be the office responsibility to review those labs or to contact you regarding them, As mentioned above, all labs and radiological studies are reviewed only during the office visit. It is your responsibility to have an office visit to discuss your results.

_____ 8) Please allow 7-10 business days to process any request for medical records. There is a charge for copying medical records of $1.00 per page for the first 25 pages, then $0.25 per page after that. **If you are picking up records you must bring a valid ID. If you send someone to pick up patient records they must be listed on the patients Authorization to Release Medical Records and must bring their valid ID and a copy of the patients ID.**

_____ 9) Forms; The cost will be $35 for 1 page. After 1 page the cost will be an additional $20 charge. EXAMPLE: 4 Pages; $35 +$20+$20+$20=$95. Writing a letter for a patient will be $75 (school forms for children are excluded from the above fee). Please note this may take 7-10 business days.

_____ 10) I will treat the staff and the providers with respect . I understand that the office has zero tolerance policy for abnormal or disrespectful behaviour.

_____ 11) For patient safety, it is not advised to give medical advice over the telephone without examination and taking proper detailed history. Therefore if you call during business hours with any symptoms we will ask you to come to the office that day. If you have a medical question please come to the office to receive your answer. If you forget what the doctor or nurse practitioner told you during your office visit please come to the office, we cannot discuss this over the phone. If you want your prescription changed to a different medication please come to the office, we cannot do this over the phone. If you need to leave a message for the doctor, nurse practitioner or nurse please allow 1-2 business days for a returned phone call. If you have any questions or concerns please do not hesitate to write your suggestion to Dr. Kamel or talk to anyone of the office staff. It is a great pleasure and honor to be able to serve you and I hope you will have outstanding experience in our office that will meet your expectations.

_____ 12) We have a remote monitoring program and chronic care program that may contact you on behalf of our practice. Participating in these programs is voluntary. You agree that you may be contacted for the above services unless you decline them.

_____ 13) You agree to download the free healow app. You agree that the Healow app is the preferred way of communicating with our office for any reason except emergencies. For emergencies call 911.

I agree to follow the above regulations Patient Signature: _____

Patient Information Packet

Name: _____ Date of Birth: _____ Age: _____ Today's Date: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Street Address: _____City:_____ State: _____ Zip: _____

Primary Language: □ English □ Other: _____ Ethnicity: □ Hispanic □ Non-Hispanic

Race: □ Native American □ Asian Indian □ Black/African American □ Chinese □ Japanese □ Korean □White
Other:_____

Gender: □ Male □ Female

Social Security Number:_____ Choice of Contact (please circle one): Phone or Mail

Spouse or responsible party:_____ Date of Birth:_____

Who is responsible for this account:_____ Relationship to the patient:_____

Do you have Medical Insurance (please circle one): Yes or No Name of Insurance Company:_____

Policy Holder Name:_____ Policy Holder Date of Birth:_____

Policy Number:_____ Group Number:_____

Emergency Contact Name:_____ Relationship to Patient:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Pharmacy Name and Address:_____

Email:_____

Please fill out all areas asked. If you have a list of your medications, surgeries and past medical history please hand it to the nurse during check-in**.**

Reason for your visit: Please list your chief complaints or concerns:

1._____

2._____

3._____

Social History:

1. Spousal Status (Please circle): Married Partnered Single Widowed
2. Living Arrangement (Please circle): Live alone or Live with others

   Live with whom? _____ Where? House, Assisted Living Facility or Retirement Facility
3. Children: How many? _____ Ages: _____
4. Occupation: _____
5. Exercise # of days per week: _____ How long per session: _____

   Type of Exercise: _____
6. Hobbies (How you spend your free time?):_____
7. Do you use tobacco products:_____ Packs per day:_____ Number of years:_____

Have you ever smoked tobacco?_____ What year did you quit?_____

8. Do you drink alcohol: Yes or No Drinks per day:_____ per week:_____ For how many years:_____

9. Have you ever used recreational drugs: Yes or No, If yes, which drugs:_____

10. Have you recently traveled out of the country: Yes or No If yes, where:_____

Family History: Please **c**ircle

Mother: Living / Deceased; Heart disease, diabetes, thyroid disease, kidney disease, stroke, cancer, other

Father: Living / Deceased; Heart disease, diabetes, thyroid disease, kidney disease, stroke, cancer, other

Sibling 1 Living / Deceased; Heart disease, diabetes, thyroid disease, kidney disease, stroke, cancer, other

Sibling 2 Living / Deceased; Heart disease, diabetes, thyroid disease, kidney disease, stroke, cancer, other

Sibling 3 Living / Deceased; Heart disease, diabetes, thyroid disease, kidney disease, stroke, cancer, other

Medical History: List all Medical Issues you have had in the past or are having currently.

Issue: Diabetes, Thyroid, Heart Disease, etc	Date of Diagnosis

Surgeries: Please list all surgeries or procedures you have had in the past and the date/year.

Name of Surgery or Procedure	Date/Year

Medications: Please list all of your medications including prescriptions, over the counter and herbal supplements.

Name of Medication	Dosage	How many times a day

Medication Allergies: Please list all medication allergies and medications you have tried in the past that did not work for you.

Medication	Reaction or Symptoms

Other Allergies: Please list any food allergies or environmental allergies such as latex, dyes, tapes, etc.

Allergy	Reaction

List all doctors or health care providers you are currently seeing:

Name of Doctor	Specialty, Area of Practice

Review of Systems: Please circle if you have recently had problems with any of the following:

General: Weight Gain: How much:_____, Over how long:_____.

Weight Loss: How much:_____, Over how long:_____.

Fatigue, Fever, Night sweats, Heat or cold intolerance, Loss of appetite or Increased appetite

Skin: Rash, Hair loss, Easy bruising, Toenail infection, Dark lines in the skin, Acne, Ulcers

Eyes: Blurry vision, Excessive tears, Redness, Pain, Discharge, Dryness, Visual changes

Nose: Nose bleed, Nasal discharge/drainage, Sinus pain, Sinus congestion

Ears: Ear pain, Ear discharge, Change in hearing, Sudden loss of hearing

Mouth: Oral lesions, White patches, Bleeding gums, Toothache

Throat: Hoarseness, Sore throat, Pain when swallowing, Difficulty swallowing, Lump in throat, Tender lymph nodes

Respiratory: Cough, Coughing blood, Shortness of breath at rest, Shortness of breath on exertion, wheezing

Cardiovascular: Chest discomfort, Palpitations (heart fluttering or racing), Ankle swelling, fast heartbeat, Difficulty breathing when laying down, Awakening short of breath.

Urinary: Pain with urination, Urinating frequently, Incontinence (losing your urine) with coughing/laughing, Urinating before you can get to the bathroom, Urination at night, Difficulty starting a urine stream, Blood in urine, Urinating large amounts

Gastrointestinal: Nausea/Vomiting, Diarrhea, Blood in the stool, Black tarry stool, Heartburn/Reflux, Constipation

Sexual: Difficulty achieving and maintaining an erection, Decreased libido

Musculoskeletal: Joint pain or stiffness: Which joints: _____
Joint swelling or redness: Which joints: _____
Back pain, Muscle pain, Rings on finger becoming tighter and or increasing in size

Neurological: Difficulty with memory, Fainting/Losing consciousness, Weakness: Which part of the body_____ Seizures, Severe or frequent headaches, Difficulty with balance, Difficulty walking, Lightheadedness, Vertigo (world spinning around you)

Psychological: Depression, Lack of interest in and enjoyment of activities that previously brought pleasure/fulfillment, Decreased sense of self-worth, Difficulty focusing and concentrating, Desire to end your life, Disabling anxiety, Panic attacks

Endocrine: Excessive facial hair, Breast discharge, Irregular Menses, Prolonged Menses, Complete loss of Menses, Hot/Cold intolerance

Hematologic/Lymphatic: Enlargement of lymph nodes, bleeding, pallor

Immunologic/Allergic: Hives, Itchy skin, Seasonal allergies

Sleep: Difficulty getting to sleep, Difficulty staying asleep, Snoring, Cessation of breathing during sleep (as reported by bed partner), Napping during the day

Health Maintenance: Please provide us with the most recent information regarding the following.

Date of your most recent Cholesterol check: _____

Have you received a Tetanus vaccine booster? Yes or No, Date: _____

Have you received the Shingles vaccine? Yes or No, Date:_____

Have you received the Pneumovax (pneumonia vaccine)? Yes or No, Date:_____

Have you received the Flu vaccine this flu season? Yes or No, Date:_____

Have you had a skin cancer screening performed by a dermatologist? Yes or No, Date:_____

Have you had a colonoscopy? Yes or No, Date: _____, Normal? Yes or No

Have you had a bone density test? Yes, No or Not Sure, Date:_____, Results:_____

For women: When was your last mammogram: _____, Abnormal: Yes or No

When was your last Pap smear: _____, Abnormal: Yes or No

Have you had a hysterectomy? Yes or No, Date:_____, Reason:_____

For men: When did you have your last digital rectal exam?_____, Normal: Yes or No

Notice of Privacy Practices

Privacy Notice - Effective Date: 09/23/2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT OUR PATIENTS MAY BE DISCLOSED UNDER THE HIPAA PRIVACY ACT OF 2013. IT DESCRIBES HOW YOU CAN GET ACCESS TO YOUR INFORMATION. These policies may be changed as the need arises.

OUR OBLIGATIONS

We are required by law to:

- **Maintain the privacy of protected health information**
- **Provide our patients with notice of our legal duties and privacy practices**
- **Provide you with information on disclosures of your PHI (Personal Heath Information) to our Business Associates who have contracts with us**
- **Follow the terms of our notice in compliance with the current HIPPA HITECH ACT and Privacy Policies**

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

WE WILL USE AND DISCLOSE HEALTH INFORMATION (PHI) ONLY WITH WRITTEN PERMISSION FROM OUR PATIENTS. You may revoke this permission at any time by writing to our privacy officer. If you revoke this authorization we will no longer use or disclose PHI for the reasons covered by your authorization. You understand that we are unable to take back any disclosures we have made prior to your revocation. We are required to maintain records of the care we provided you.

FOR TREATMENT
We may disclose your PHI (Personal Health Information) for your treatment, to receive payment from you, and to an insurance or third party for treatment and services you received. We can disclose to doctors, nurses, medical technicians, and other personnel involved in your medical care. NOTE: You can block insurance and third party payers from receiving this information with notification to us when you are paying for services fully out of pocket.

FOR PAYMENT
We may disclose PHI so that we or others may receive payment for services unless you are paying out of pocket and have asked us not to disclose this information.

HEALTH OPERATION
We may share information with other entities that have a healthcare delivery relationship with you. We may share with state and federal public health entities for epidemiological and surveillance of disease outbreaks.

APPOINTMENT REMINDERS TREATMENT ALTERNATIVES AND HEALTH RELATED BENEFITS
We may use and disclose PHI to contact you to remind you of an appointment with us, tell you about treatment alternatives or health related benefits.

DESCENDANTS, INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR CARE
When appropriate, we may share PHI with a person who is involved in your care or payment for your care such as a family member or close friend. We may also notify your family about your location or general condition or disclose such information to an entity assisting in disaster relief efforts.

RESEARCH
The use of research leads to developing new knowledge to improve healthcare. We may ask you to allow us to use your PHI for research studies if they meet the federal and state requirements and use your information in a delimited (de-identified) data format. We will not allow the use of your PHI for marketing and will consider this a breach by any entity with a BA agreement doing so.

HEALTH INFORMATION EXCHANGE/REGIONAL HEALTH INFORMATION ORGANIZATIONS
Federal and state laws may permit us to participate in organizations with other healthcare providers and other healthcare industry participants in order to share PHI with one another to accomplish the goal of increasing access to your PHI; aggregate and compare your information for quality improvement purposes as is permitted by law.

SPECIAL SITUATIONS FOR DISCLOSURE

We are required under international, federal, state and local laws to disclose PHI:

- **To avert serious threats to health and public safety** as in the case of epidemics, child abuse or neglect, report deaths or births or injury due to natural disasters. Public Health entities may also be involved in health oversight activities
- **Business Associate (BA's) that perform functions associated on our behalf** to provide us with services. All our BA's are obligated under contract to not disclose PHI
- **Organ and Tissue Donation entities handling the procurement, banking or transportation of the organ**
- **Military & Veteran entities with direct command authority over our patient**
- **Workers Compensation programs may receive information related only to a specific work related injury**
- **Data Breach Notification Purposes** - to provide legally required notices of unauthorized access to or disclosure of PHI to the secretary of OCR (Office of Civil Rights) and HHS (Health and Human Services)
- **Lawsuits and Disputes** - if you are involved in a lawsuit we may disclose PHI in response to a subpoena, discovery request, or other lawful process in the dispute. This will only happen if efforts are made by us to notify you of the request.
- **Law Enforcement** - We may release information to a law enforcement official if the information is in response to: 1. A court order 2. Limited information to identify and locate a suspect, fugitive, material witness or missing person 3. About the victim of a crime 4. About a death we believe may be a part of some criminal activity 5. Criminal conduct on our premises 6. In an emergency to report a crime, it's location or victims and the location of the person who committed the crime.
- **Corners, Funeral Directors and Medical Examiners** - this information may be necessary to identify a deceased person and the cause of death. This information is necessary for the Funeral director to complete a death certificate.
- **National Security and Intelligence Services** - PHI may be released to federal officials for intelligence, counter intelligence and other national security activities authorized by laws.
- **Inmates or Individuals in Custody** - if you are an inmate of a correctional institute receiving our medical services, we may release PHI in order for the institution to provide you with health care to protect your health and that of other inmates and the safety and security of the correctional institution.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

These disclosures of PHI require your written consent:

1. Use and Disclosure of Psychotherapy notes
2. Use and Disclosure of HIV laboratory test results
3. Use and Disclosure for marketing purposes
4. Use and Disclosure of any Genetic Information under (GINA ACT)

PATIENTS RIGHTS CONCERNING PHI

Of the PHI

1. **Right to Inspect and Copy** - your medical and billing records under than psychotherapy records. We have up to 30 days to make the information available and we may charge for the copies. We may not charge a fee if you need the records for Social Security or any other federal or state needs based benefit programs. We may deny the request to information that was not created by this entity
2. **Right to an Electronic Copy of Electronic Medical Records - if we have your health information in an electronic medical records (EMR)**, you have a **right to receive a copy given to you in an electronic format or transmitted to you or another entity. We may charge a reasonable cost based fee for the labor associated with transmitting or delivering**

the PHI in an electronic format. ***We will make every effort to provide access to your PHI in the form or format you requested if it is readily available in such a format in this facility***

3. **Right to get notice of a Breach-involving unsecured PHI**
4. **Right to Amend - you have a right to ask for an amendment of PHI information kept by our office. This request must be made in writing to the office manager**
5. **Right to Accounting of Disclosures** - we will supply you with a list of disclosures we made for treatment, payment or other health operations for which you provided written authorization or they were covered by law. Accounting disclosure requests must be submitted in writing to the office manager
6. **Right to Request Restrictions** - you have the right to request a restriction or limitation on any disclosure of your PHI. Request for restrictions need to be made in writing. We are required to agree to your request if you are requesting restricting the disclosure to a health plan for payment or health operation purposes and the information you wish to restrict pertains solely to a health care item for which you have paid "out-of-pocket"
7. **Right to request confidential information** - you have the right that we communicate your medical matters with you in a certain way or location. To request confidential communication you must make your request in writing
8. **Right to a Paper Copy of this Notice**

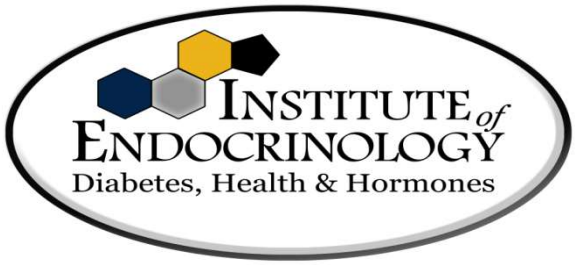
CHANGES TO THIS NOTICE MAY BE MADE AT ANY TIME - This notice will be posted and available in paper copy at any time.

COMPLAINTS - We will not penalize you for filing a complaint

DR. KAMEL, Privacy Officer, 633 E Baldwin Rd, Panama City, FL 32405 (850) 522-5490
File a complaint with the Secretary of Human Services: Secretary of the US Department of Health and Human Services, 200 Independence Ave. S.W. Washington, and D.C. 20201

Signature: _____

Date: _____



AUTHORIZATION TO RELEASE INFORMATION

THE FOLLOWING PEOPLE NAMED BELOW MAY OBTAIN MEDICAL INFORMATION FOR ME, AND MAY SPEAK FOR ME IF I WAS TO BECOME UNABLE TO EXPRESS MY WISHES.

NAME: _____RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____PHONE: _____

I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES (HIPPA) AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

NAME: _____ BIRTH DATE: _____

SIGNATURE: _____ DATE: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN THE PLACE OF THE ORIGINAL.

DATE: _____ SIGNATURE: _____
PATIENT, PARENT OR GUARDIAN

I HEREBY AUTHORIZE IEDHH TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED BY HIM OR BY HIS ORDER. I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO IEDHH, OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT.

I PERMIT A COPY OF THE AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. THIS AUTHORIZATION MAY BE REVOKED BY EITHER ME OR MY INSURANCE COMPANY AT ANY TIME IN WRITING.

DATE: _____ SIGNATURE: _____
PATIENT, PARENT OR GUARDIAN

THANK YOU

Authorization to Obtain, Release or Review Protected Health Information (PHI)

I _____
(Print Name) (DOB) (SS#)

Hereby authorize **Institute of Endocrinology, Diabetes, Health and Hormones**

- ☐ to obtain from Dr. _____
- ☐ to release to Dr. _____
- ☐ to release to me (enter your home address below)

_____
(Name of Doctor) (Phone number)

_____
(Address) (Fax number)

- ☐ All medical information and reports
- ☐ Prenatal medical records
- ☐ Physical examination reports
- ☐ Laboratory reports
- ☐ Immunizations
- ☐ Radiology reports and images
- ☐ Sexually transmitted disease reports
- ☐ Psychiatric/Psychological reports
- ☐ HIV/AIDS test results
- ☐ Other (please specify) _____

Please specify anything that you do NOT want to be released:

_____

The purpose of the release of information:

_____

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or HIV/AIDS test results. I expressly consent to the release of information as designated above.
I understand this authorization will remain in effect for one year unless otherwise specified. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. **I understand that after signing this form, there is a processing period of 7–10 business days and may be subject to a processing fee of $1.00 per page for the first 25 pages and the .25 for pages 26+. The processing fee does not apply to records sent to a healthcare provider.**

Patient/Legal Representative or Parent/Legal Guardian Date

_____

Laboratory and Radiological Testing

Acknowledgement

The practice will usually order tests (laboratory or radiological tests) based on your clinical case and your medical complaints in order to make diagnosis and establish a treatment plan.

You must understand that not every test we order or consider as important to you will necessarily be covered and paid for by your insurance. It is your responsibility as the patient to check with your insurance if they cover and pay for the test or study based on your diagnosis.

Please check with your insurance about coverage before every lab or radiological test you undergo. Again, it is not the responsibility of the office if your insurance does not cover a certain test or service.

_____
Signature

_____
Print

_____
Date

Billing Policies

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.
On arrival, please sign in at the front desk and present your current insurance card at visit. You will be asked to sign and date the file copy of the card. This is your verification of the correct insurance and consent to bill them on your behalf.

IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT.

1. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances at the time of visit. YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT.
2. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
3. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
4. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
5. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due *within* 10 business days of your receipt of your bill.
6. If previous arrangements have not been made with our finance office any balance over 60 days will be forwarded to a collection agency.
7. If you participate with a high-deductible health plan, we require a copy of the health savings account debit/credit card or a personal credit card remains on file.
8. A **$20.00** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
9. It is your responsibility to know if a selected specialist participates in your plan.
10. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s) _____

_____ _____
Responsible party member's name Relationship

_____ _____
Responsible party member's signature Date