Endo Care of South Florida

Center for Endocrine and Diabetes Care

Acknowledgment Form of Endo Care of South Florida

Patient's Name_____ Date of Birth _____/_____/_____

Day Month Year

We are required by law to provide you with our Notice of Privacy Practices which explain how we use and disclose your health information. We are also requires to obtain your signature acknowledging that this notice has been made available to you.

Signature: _____ Date: _____

(Patient or Authorized Representative)

Relationship to patient:____Self_____Spouse_____Other

Reason Patient Unable/Unwilling to Sign:_____

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Cancellation Policy

Please keep in mind that the office of Dr. Miguel holds a 24 hours cancellation policy**.**

If you fail to cancel or reschedule your appointment with a minimum of 24 hours prior to your scheduled time, a $50 fee will apply.

The office provides you with appointment reminders through a courtesy call 48 hours prior to your appointment to avoid this fee being added to your account. Nevertheless, it is your responsibility to cancel or reschedule your appointment with 24 hours notice.

Signature:_____

Thank you

Dr. Ihosvani Miguel