

CONSENT & FINANCIAL AGREEMENT

Medical consent for Treatment: The undersigned hereby grants authorization for treatment and procedures that are deemed necessary by his/her physician. The undersigned is aware that the practice of medicine is not an exact science, and the undersigned acknowledges that no guarantees have been made as to the result of treatment rendered.

Release of Information: The undersigned hereby authorizes Atlanta Diabetes Associates and/or Diabetes Supply and Training Center to release to third party payers' pre-certification or medical records information regarding his/her examination or treatment for purposes of obtaining insurance compensation.

Financial Agreement: For and in consideration of the goods and services rendered and to be rendered by or through Atlanta Diabetes Associates and/or Diabetes Supply and Training Center, the undersigned agrees to make payment in full upon receipt of final billing.

Warranty Disclaimer: Atlanta Diabetes Associates and/or Diabetes Supply and Training Center make no representation or warranty of any kind, expressed or implied, with respect to any goods sold hereunder or otherwise provided in connection with any services rendered, whether to merchantability, fitness for a particular purpose, or any other matter.

THE UNDERSIGNED CERTIFIES THAT HE/SHE READ THE FOREGOING, THAT ANY QUESTIONS HAVE BEEN FULLY EXPLAINED, AND THAT HE/SHE UNDERSTANDS ITS CONTENTS. THE UNDERSIGNED HEREBY AGREES TO ALL TERMS SET FORTH IN THIS DOCUMENT.

Signature of Patient or Legal Guardian

Date

Patient's name (Print)

Date

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Atlanta Diabetes Associates to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Atlanta Diabetes Associates' Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Atlanta Diabetes Associates reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Atlanta Diabetes Privacy Office at 1800 Howell Mill Rd, Suite 450, Atlanta, GA 30318.

With this consent, Atlanta Diabetes Associate's may call my home, send e-mail or mail to my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO. These items include but are not limited to appointment reminders, insurance items, correspondence from the physicians, any calls pertaining to clinical care, including laboratory results, and patients statements.

I have the option to request that Atlanta Diabetes Associates restrict how it uses discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restricted, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Atlanta Diabetes Associates' use and disclosure of my PHI to carry out TPO with those organization and health providers necessary for my medical care.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Atlanta Diabetes Associates may decline to provide treatment to me.

There may be fees for provision of any or all request information

Atlanta Diabetes Associates Office and Financial Policy

Welcome and thank you for choosing Atlanta Diabetes Associates for your medical care. We are committed to providing you with the highest quality medical care possible and in a cost effective manner. We are pleased to discuss with you any questions you may have concerning a bill.

Payment is due in full at the time services are rendered. As a courtesy to our patients, we accept cash, personal check, money order, Visa, MasterCard, Discover, and American Express.

We provide our patients with the ability to pay for their accounts online at www.atlantadiabetes.com or over the phone at 404-355-4393.

OFFICE HOURS: Our clinic is open Monday – Thursday, 8:00am – 4:30pm and Friday from 8:00am – 3:30pm.

MYCHART: We strongly encourage that all correspondence be done through your MYCHART account. Please be aware that your MYCHART messages are only checked during normal business hours. DO NOT leave urgent messages on this system after hours and on weekends.

AFTER HOURS and EMERGENCIES: For a serious emergency call 911 immediately. If you are not sure whether you need emergency assistance and you call our office, please be sure to tell the person who answers the phone that it is an emergency. After hours you will reach our answering service. They will page the provider on call.

PRESCRIPTION REFILLS: Do not wait until the last minute to request medications. It is **your** responsibility to keep up with your medications. You can expect a 24-48 hour turn-around time for prescriptions to be sent to your pharmacy. **Request for medications made after NOON on Friday will not be addressed until Monday.** The on-call doctor will not refill routine or controlled medications after hours during the week or anytime on the week-ends. We **WILL NOT** refill medications prescribed by another physician. This includes pain meds, antidepressants, etc. We **WILL NOT** refill medications for patients not that have not been recently seen. This will be determined by the physician.

APPOINTMENTS: Please arrive for your appointment 15 minutes early. When you arrive for your appointment please inform the front desk of any changes in demographics (phone number, address, insurance, information, etc.). If you are more than 15 minutes late for your appointment, you may be considered a NO SHOW and may need to reschedule your appointment.

MISSED OR CANCELLED APPOINTMENTS AND OTHER FEES: Missed appointments are subject to a \$25 NO SHOW fee. All appointments need to be cancelled at least 24 hours ahead of time in order to avoid this fee.

INSURANCE: Although we are contracted with several insurance companies, it is your responsibility to know your insurance benefits. We will verify that the visit is covered before each visit to help ensure your coverage is active. It is important that if you have any changes in demographics or coverage's notify us immediately. Any dispute you have about coverage's will need to be handled directly with your insurance carrier. We offer a reasonable discount to our self-pay patients and payment is due at the time of service.

PAYMENTS AND OUTSTANDING BALANCES: Our practice is happy to work with you in order to pay any balances due. Please contact our billing department to work out any payment plans. We reserve the right to add a \$10 monthly statement fee on any account that has an unpaid balance. Any outstanding balance older than 60 days will be referred to an outside collection agency and may be subject to a 10% collection fee and you may be discharged from the practice. Any returned checks will be charged a \$25 bank fee.

ADMINISTRATIVE FEE: Completing forms such as FMLA forms, disability forms, workers compensation, medial releases, letters for employers, school, health clubs, etc...require time away from patient care and day to day business operations. We will charge a \$10 fee per form up to \$30 a year or you can pay a flat fee of \$25 yearly to cover all forms needed in any calendar year. Please choose one below.

* I choose to pay the Annual Administrative Fee of \$25.00 per year.

*I understand that by not choosing the annual Administrative Fee, I will be charged \$10.00 per form for my physician to complete.

* I also understand that it is **my responsibility to know if my provider participates in my plan and that any/all fees not covered by my plan will be my responsibility.**

* I acknowledge that I have received and read a copy of the **Atlanta Diabetes Associates office and financial policy.**

*I acknowledge that I have received and read a copy of the **Patient Consent for use and disclosure of Protected Health Information.**

By signing this form I acknowledge all of the above:

Signature/ Parent or Guardian

DATE



ATLANTA DIABETES ASSOCIATES

ENDOCRINE SPECIALTY GROUP

Today's Date: _____

Patient Name: _____ Date of Birth: _____

General Health Excellent Good Fair Poor

Reason for today's visit: _____

Date this was 1st diagnosed: _____

Allergies: _____

MEDICAL HISTORY

Please write date of diagnosis/event in the space provided

Allergies	_____	Eating disorder	_____	Neuropathy	_____
Anemia	_____	Emphysema	_____	Osteoporosis	_____
Anxiety	_____	Glaucoma	_____	Osteopenia	_____
Arthritis	_____	Goiter	_____	Reflux	_____
Asthma	_____	Graves	_____	Seizures	_____
Blood transfusion	_____	Hashimotos	_____	Sickle cell anemia	_____
Cancer	_____	Heart murmur	_____	Stroke	_____
Cataracts	_____	HIV/AIDS	_____	Substance abuse	_____
Congestive heart failure	_____	Hypertension	_____	Thyroid nodules	_____
Chronic Obstructive pulmonary Disease	_____	Hyperthyroidism	_____	Transplant	_____
Clotting disorder	_____	Hypothyroidism	_____	Tuberculosis	_____
Depression	_____	Infertility	_____	Ulcers	_____
Diabetes - Type 1	_____	Kidney disease	_____	Radiation to _____ (area)	
Diabetes - Type 2	_____	Meningitis	_____	Fractures _____ (area)	
Other diagnoses/events	_____				

Last Foot Exam _____ Last Dilated Eye Exam _____ Last Thyroid Ultrasound _____
Last Colonoscopy _____ Last Mammogram _____ Last Thyroid Biopsy _____
Last Bone Density Scan _____

SURGICAL HISTORY

Please write date of surgery in the space provided

Appendix	_____	Cosmetic surgery	_____	Cataract surgery	_____
Brain surgery	_____	Eye surgery	_____	Prostate surgery	_____
Heart Bypass	_____	Fracture surgery	_____	Vasectomy	_____
Gall Bladder	_____	Hernia repair	_____	Spine surgery	_____
Colon Surgery	_____	Hysterectomy	_____	Tubal Ligation	_____
Tonsillectomy	_____	Joint replacement	_____	C-Section	_____
Transplant	_____	Thyroidectomy	_____	Stomach Surgery	_____
Heart Valve Replacement	_____	Parathyroidectomy	_____	Small Intestine surgery	_____

Other surgeries: _____

FAMILY HISTORY

Please check off all that apply

	Current Age	Age Deceased	Alcohol abuse	Arthritis	Autoimmune disease	Asthma	Cancer	COPD	Depression	Diabetes	Drug abuse	Early death	Hearing loss	Heart disease	Hepatitis	High Cholesterol	High Blood Pressure	Kidney disease	Learning disabilities	Mental illness	Stroke	Thyroid disease	Tuberculosis	Vision loss
Mother																								
Father																								
Sister(s)																								
Brother(s)																								
Daughter(s)																								
Son(s)																								

Other family history: _____

SOCIAL HISTORY

How much planned exercise do you get per week?: 0 1 2 3 4 5 6 7 days for 30 60 90 minutes

Occupation: _____ Hours worked per week: _____

Highest Level of Education: High School Trade School College Post Grad

Diet:

How many times per week do you eat fast food? _____

How many times per week do you eat out? _____

How many times per week do you eat fried food? _____

How many times per week do you eat healthy? _____

How many times per week do you skip meals? _____

Social History Continued

Weight at age 20: _____

How many hours do you spend sitting in a day: _____

Are you currently sexually active?: Yes No Using Contraceptives Yes No

Do you drink alcohol?: Yes No

Tobacco Use:

Never Smoker Current Some Day Smoker Current Everyday Smoker Former Smoker
Packs per day: _____ Packs per day: _____ Quit Date: _____
Years: _____
Packs per day: _____

Smokeless Tobacco

Never Used Current Some Day User Current Everyday User Former User
Packs Per Day: _____ Packs Per Day: _____ Quit Date: _____
Years: _____
Packages Per Day: _____

Electronic Cigarette Other _____

Illicit / Recreational Drug Use: Yes: No

Current Medications (include dose and directions)

**Mail order and local pharmacies currently being used
(include address and phone number)**

Immunizations

When did you last have the following:

Flu Shot	_____	Tetanus/Tdap	_____
Pneumovax 23	_____	Shingles Vaccine	_____
Pneumovax 13	_____	Hepatitis	_____

Review Of Systems

Please mark any problems you are currently having or have had

Problem	Yes	No	Date started
Change of appetite	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Change in weight	<input type="checkbox"/>	<input type="checkbox"/>	_____

EENT	Yes	No	Date started
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Throat, voice, or neck issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
Changes in eyes or vision	<input type="checkbox"/>	<input type="checkbox"/>	_____

Respiratory	Yes	No	Date started
Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	_____

Cardiovascular	Yes	No	Date started
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Leg swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other heart problems	<input type="checkbox"/>	<input type="checkbox"/>	_____

Gastro	Yes	No	Date started
Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Digestion issues	<input type="checkbox"/>	<input type="checkbox"/>	_____

Endocrine	Yes	No	Date started
Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Increased thirst, urination or hunger	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast changes	<input type="checkbox"/>	<input type="checkbox"/>	_____

GU	Yes	No	Date started
Changes in bladder habits/urine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fertility issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>	_____

Musculoskeletal	Yes	No	Date started
Muscle or joint problems	<input type="checkbox"/>	<input type="checkbox"/>	_____

Skin	Yes	No	Date started
eye/hair/nail changes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excessive bruising	<input type="checkbox"/>	<input type="checkbox"/>	_____

Neurology	Yes	No	Date started
Headache	<input type="checkbox"/>	<input type="checkbox"/>	_____
Numbness or weakness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other nerve problem	<input type="checkbox"/>	<input type="checkbox"/>	_____

Psych	Yes	No	Date started
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>	_____