ATLANTA DIABETES ASSOCIATES

ENDOCRINE SPECIALTY GROUP

Date: _______________ Sex: M or F

Patient Name: ____
First Middle Last

Address: ____

City: ____________________________ State: _______________ Zip Code: ____________________

Date of Birth: ______________ Social Security: _______________ Marital Status: S M D W

Home Phone: _________________ Work Phone: __________________ Cell Phone: ______________

Email Address: ____Employment Status:__________

Ethnicity (circle one) Hispanic or Latino, Not Hispanic or Latino, Patient Refused

Race (circle one) American Indian or Alaska Native, Asian, Black or African American,
Native Hawaiian or Other Pacific Islander, White or Caucasian, Patient Refuse

Physician you were referred by? (Doctor's first and last name)_______________________________

Doctor's Phone Number: __________________________ Fax Number: _________________________

Who's your Primary Physician? (Doctor's first and last name)_______________________________

Doctor's Phone Number: __________________________ Fax Number: _________________________

Primary Insurance: _____________________________________Effective Date: ________________

Policy Holder's Name: __________________________ DOB: __________ SS# __________________

Relationship to Patient: _____________ Insurance ID# __________________ Group #: ______________

Group Name: ___________________________ Copay: ____________

Secondary Insurance: ____________________________________ Effective Date: ______________

Policy Holder's Name: _______________________ DOB: ____________ SS# ___________________

Relationship to Patient: _______________ Insurance ID #__________________Group #: ____________

Group Name: ___________________________ Copay: ____________

Emergency Contact Person: __________________________ Relationship to Patient: ____________

Emergency Phone Number: _____________________________________

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:

Effective 2024: Missed appointments are subject to a $75 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	______
		Hypothyroidism	______	Tuberculosis	______
Clotting disorder	______	Infertility	______	Ulcers	______
Depression	______	Kidney disease	______	Radiation to	______ (area)
Diabetes - Type 1	______	Meningitis	______	Fractures	______ (area)
Diabetes - Type 2	______	Heart attack	______		

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	Turberculosis	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 ☐
Packs per day: ______________

Current Everyday Smoker ☐
Packs per day: ______________

Former Smoker ☐
Quit Date: ______________
Years: ________________
Packs per day: __________

Smokeless Tobacco

Never Used ☐

Current Some Day User ☐
Packs Per Day: ______________

Current Everyday User ☐
Packs Per Day: ______________

Former User ☐
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 ____________________
Pneumovax 23 ____________________
Pneumovax 13 ____________________

Tetanus/Tdap ____________________
Shingles Vaccine ____________________
Hepatitis ____________________

Review Of Systems

Please mark any problems you are currently having or have had

Problem	Yes	No	Date started
Change of appetite	☐	☐	____________
Fatigue	☐	☐	____________
Change in weight	☐	☐	____________

EENT	Yes	No	
Dental problems	☐	☐	____________
Throat, voice, or neck issues	☐	☐	____________
Changes in eyes or vision	☐	☐	____________

Respiratory	Yes	No	
Cough	☐	☐	____________
Shortness of breath	☐	☐	____________

Cardiovascular	Yes	No	
Chest pain	☐	☐	____________
Leg swelling	☐	☐	____________
Palpitations	☐	☐	____________
Other heart problems	☐	☐	____________

Gastro	Yes	No	
Stomach pain	☐	☐	____________
Digestion issues	☐	☐	____________

Endocrine	Yes	No	
Cold intolerance	☐	☐	____________
Heat intolerance	☐	☐	____________
Increased thirst, urination or hunger	☐	☐	____________
Breast changes	☐	☐	____________

GU	Yes	No	
Changes in bladder habits/urine	☐	☐	____________
Fertility issues	☐	☐	____________
Sexual problems	☐	☐	____________

Musculoskeletal	Yes	No	
Muscle or joint problems	☐	☐	____________

Skin	Yes	No	Date started
eye/hair/nail changes	☐	☐	____________
Excessive bruising	☐	☐	____________

Neurology	Yes	No	
Headache	☐	☐	____________
Numbness or weakness	☐	☐	____________
Other nerve problem	☐	☐	____________

Psych	Yes	No	
Depression	☐	☐	____________
Difficulty sleeping	☐	☐	____________