

NORTH ATLANTA ENDOCRINOLOGY AND DIABETES, P.C.
771 OLD NORCROSS ROAD, SUITE 200
LAWRENCEVILLE, GA 30046
770-339-1387 OFFICE
770-962-7868 FAX

Dear

We want to welcome you to our practice and thank you for giving us the opportunity to assist in your healthcare needs. We want your first visit to be as efficient as possible. Therefore, we want to give you some information including a list of steps to take before and on the day of your visit.

FORMS: Please fill out and sign the enclosed patient information, personal medical history and policy forms. We understand your time is valuable and we prefer that your wait time is minimal. Therefore, we need all forms completed **prior to your visit** and you may fax or mail them to the office. However, if you choose to fax your records, please also bring the originals to your appointment as sometimes faxed documents are blurry and hard to read. Ideally, we should receive your paperwork 2-3 days in advance, so they may be scanned and entered into our system. However, if you are unable to return them to us before your visit and choose to bring them on the day of your appointment, please arrive at least 30 minutes early so we can prepare your chart. If you decide to come at your scheduled appointment time and complete forms, it will increase your wait time exponentially and in some cases the visit may even need to be rescheduled.

IDENTIFICATION: In order to ensure and protect your identity, we require that you bring a photo i.d. with you. Your driver's license is always best.

MEDICAL RECORDS: Most of our patients are referred by another physician. We ask that you bring your medical records from that physician on the day of your visit or have them faxed to our office. If you have self-referred to us, please bring medical records that show us any previous care. We cannot stress the importance of this step. Office notes, lab results and pertinent radiology reports are the most helpful. We only need them for the past year. Failure to have these records could severely delay your visit.

INSURANCE: Please bring your insurance card(s) with you so we may scan them. Patients who have an HMO that requires a referral to see a specialist need to bring that referral with them as well.

PLEASE NOTE-Unfortunately, we are unable to perform DOT screenings, disability evaluations or prescribe medications for nursing home or assisted living patients.

MEDICAL INFORMATION: Please bring a complete list of all current medications including the dosage. Diabetic patients should bring blood sugar readings for the two weeks prior to your appointment or bring your glucose meter.

Please feel free to call with any questions you may have. We look forward to meeting you.

The Staff of North Atlanta Endocrinology and Diabetes, P.C.

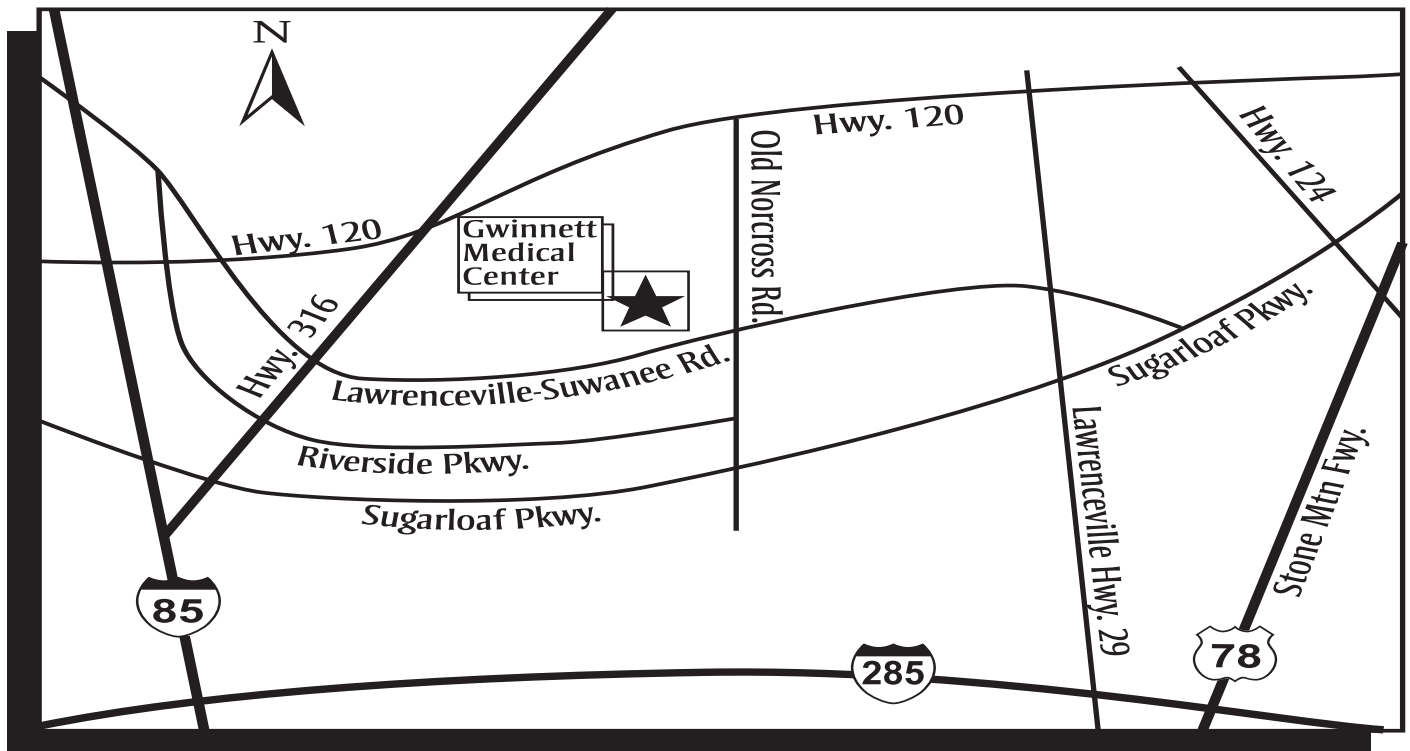
AS A REMINDER...

You are scheduled to see _____ at _____ on _____
 in the Lawrenceville Office Bethlehem Office **Phone 770-339-1387**

PLEASE BRING...

Insurance Card Driver's License or Photo ID Medical Records (please refer to Welcome Letter)
 If you are diabetic: Glucose Meter Blood Sugar Readings All Medications

LAWRENCEVILLE OFFICE 771 Old Norcross Road, Suite 200, Lawrenceville, Georgia 30046



Directions to Lawrenceville Office: Our office is located at the intersection of Old Norcross Road and Lawrenceville-Suwanee Road.

From 85 North: Take 316E to Riverside Parkway. Turn right and go .7 miles to Old Norcross Road. Turn left. Go .8 miles to the intersection of Old Norcross Road and Lawrenceville-Suwanee Road. Make a left on to Lawrenceville-Suwanee Rd. and we are the first entrance on the right.

From Snellville and Hwy 78: Take Hwy 124 toward Lawrenceville. Turn left at Sugarloaf Parkway. Go 2 miles and turn right at Lawrenceville-Suwanee Rd. Cross Old Norcross Road then we are the first entrance on the right.

From Athens/Hwy 316W: Take 316W to Riverside Parkway. Turn left and go .7 miles to Old Norcross Road. Turn left. Go .8 miles to the intersection of Old Norcross Road and Lawrenceville-Suwanee Road. Make a left on to Lawrenceville-Suwanee Rd. and we are the first entrance on the right.

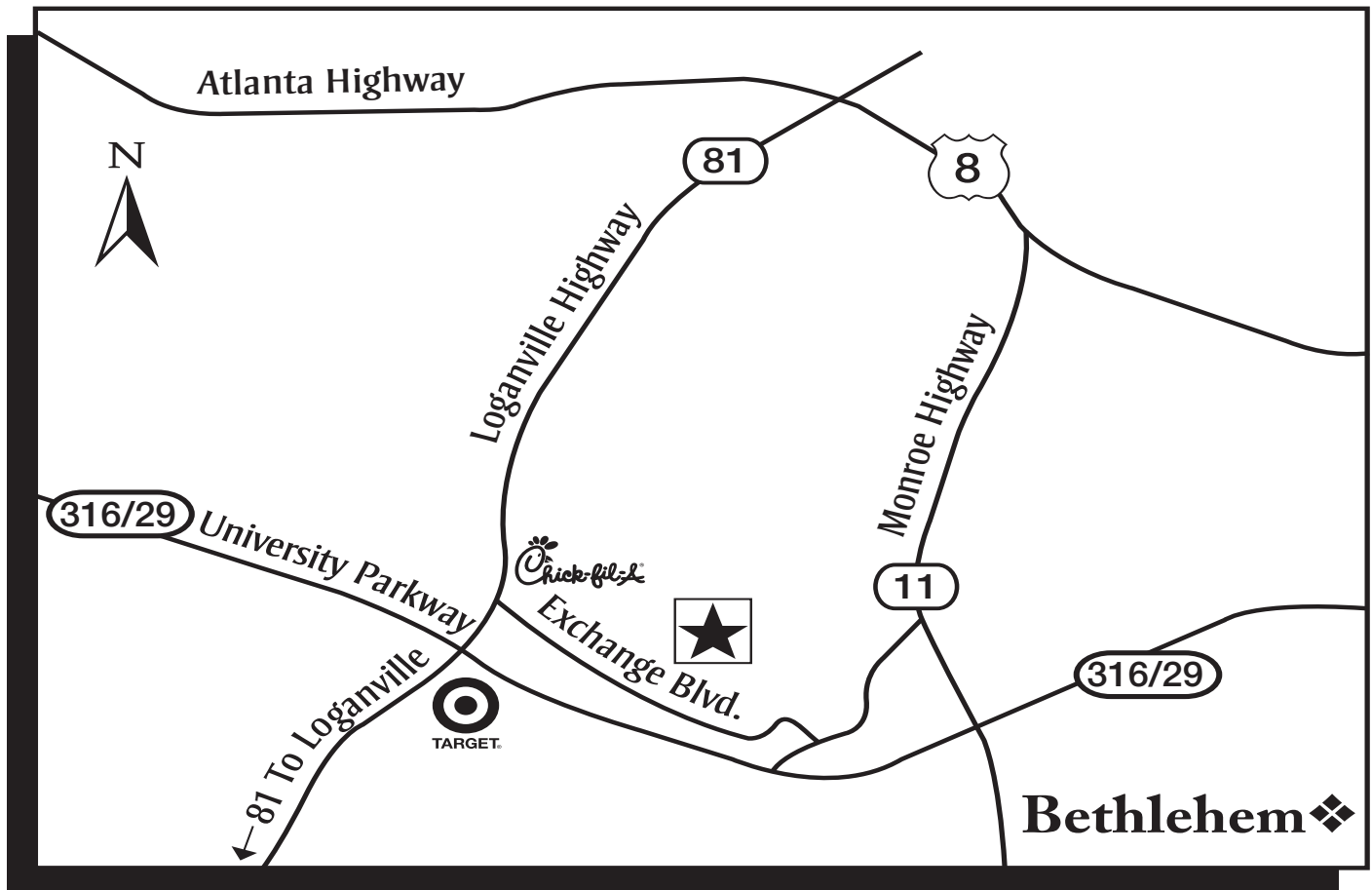
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If you are diabetic: Glucose Meter Blood Sugar Readings All Medications

BETHLEHEM OFFICE Piedmont Physician's Building, 340 Exchange Boulevard, Suite 110, Bethlehem, GA 30620



©MBC

Directions to Bethlehem Office: We are located in the Piedmont Physicians Building at 340 Exchange Boulevard, which is between Hwy. 81 and Harry McCarty Rd.

From Atlanta: Take I85 North to exit 106/Hwy 316 east. Go 21 miles to Harry McCarty Rd., (First left past Hwy 81) Turn left, go .2 miles then turn left onto Exchange Blvd. North Atlanta Endocrinology and Diabetes located in the Piedmont Physicians Building.

From Athens/Hwy 316W: Take Highway 316 west to Harry McCarty Rd., (First right past Hwy 11) Turn right, go .2 miles then turn left onto Exchange Blvd. North Atlanta Endocrinology and Diabetes located in the Piedmont Physicians Building.

North Atlanta Endocrinology and Diabetes, P.C.
Patient Information Sheet

Demographic Information

Patient ID #: _____

First Name: _____ Middle: _____ Last Name: _____

Prefix: _____ Suffix: _____ Nickname: _____ Maiden Name: _____

DOB: _____ Age: _____ Sex: _____ SSN: _____

Marital Status: _____ Employer: _____

Federal regulations now require that we collect the following demographic information below				
Race:	American/Indian/Alaska	Asian	White	Are you of Hispanic/Latino descent? YES / NO
Please Circle	Black/African American	Nat Hawaiian/Pacific Islander	Other Race	

Contact Information

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Phone numbers (Please check the box next to the best number to reach you)

Home: _____ Work: _____ Cell: _____

Email: _____

Primary Care/Family Doctor: _____ Referring Doctor: _____

Preferred Pharmacy (Name, City, & Street:): _____ Mail Order Pharmacy: _____

Emergency Contact: _____ Phone #: _____

Billing Information

For patients under 18 or who have a legal guardian:

Guarantor: _____ Address: _____ Phone #: _____

Primary Ins:	Address:
_____	_____
Policy #: _____	Group #: _____
Policyholder: _____	Relationship: _____
DOB: _____	SSN #: _____

Secondary Ins:	Address:
_____	_____
Policy #: _____	Group #: _____
Policyholder: _____	Relationship: _____
DOB: _____	SSN #: _____

I understand that I will be responsible for any co-insurance, deductible, or spend-down not covered by my insurance. If any balance is not paid when due I understand that I will be responsible for the balance. I also understand that if the unpaid account is referred to an outside agency, I am responsible to pay all costs of collection including attorney fees. I hereby authorize the release of information to my insurance carrier or its intermediaries for all covered services rendered by North Atlanta Endocrinology and Diabetes, P.C.

Signature: _____

Date: _____

<p>Family History: Parents, Grandparents, Brothers, Sisters, Children, Aunts and Uncles</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; width: 10%;">Yes</th> <th style="text-align: left; width: 10%;">No</th> <th style="text-align: left; width: 35%;">Disease:</th> <th style="text-align: left; width: 45%;">Relative(s):</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Asthma</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Cancer</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Diabetes</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Heart Disease</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>High Blood Pressure</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Kidney Disease</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Mental Illness</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Other Glandular Disease</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Stomach Ulcers</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Stroke</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Thyroid Disease/Goiter</td><td>_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Tuberculosis</td><td>_____</td></tr> </tbody> </table>	Yes	No	Disease:	Relative(s):	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	_____	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	_____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	_____	<input type="checkbox"/>	<input type="checkbox"/>	Other Glandular Disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	_____	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	_____	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease/Goiter	_____	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	_____	<p>Social History:</p> <p>Do you use alcohol? <input type="checkbox"/> Never <input type="checkbox"/> Former <input type="checkbox"/> Some Days <input type="checkbox"/> Everyday</p> <hr/> <p>Do you drink caffeinated beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>Have you ever smoked? <input type="checkbox"/> Never <input type="checkbox"/> Former <input type="checkbox"/> Some Days <input type="checkbox"/> Everyday If yes, how many years have you smoked? _____ Packs per day? _____</p> <hr/> <p>How often do you exercise? <input type="checkbox"/> Never <input type="checkbox"/> 1x per wk <input type="checkbox"/> 2-3x per wk <input type="checkbox"/> 4+x per wk</p> <hr/> <p>Are your parents living? <input type="checkbox"/> Mom <input type="checkbox"/> Dad How many siblings do you have? _____ How many children do you have? _____ Highest level of education? _____ Occupation: _____</p>
Yes	No	Disease:	Relative(s):																																																		
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	_____																																																		
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	_____																																																		
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____																																																		
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<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	_____																																																		

Symptoms: Please check the appropriate boxes indicating the symptoms you have had within the last year.

<p>CONSTITUTIONAL</p> <input type="checkbox"/> Change in weight of more than 10 lbs. <input type="checkbox"/> Night Sweats <input type="checkbox"/> Fatigue <p>EYES</p> <input type="checkbox"/> Trouble with Vision <input type="checkbox"/> Changes in Vision <input type="checkbox"/> Double Vision <input type="checkbox"/> Blurred Vision <p>HEAD ENT</p> <input type="checkbox"/> Changes in Hearing <input type="checkbox"/> Hoarseness <input type="checkbox"/> Headaches <p>BREASTS</p> <input type="checkbox"/> Changes in Skin <input type="checkbox"/> Masses <input type="checkbox"/> Nipple Discharge <p>PSYCHIATRIC</p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty Breathing	<p>CARDIOVASCULAR</p> <input type="checkbox"/> Palpitations <input type="checkbox"/> Chest Pain <input type="checkbox"/> Difficulty Breathing on Exertion <input type="checkbox"/> Lower Extremity Swelling <input type="checkbox"/> Loss of Consciousness <p>RESPIRATORY</p> <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Coughing Blood <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Difficulty Breathing <p>GASTROINTESTINAL</p> <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Reflux <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting Blood <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in Stools <input type="checkbox"/> Changes in Bowel Habits	<p>GENITOURINARY</p> <input type="checkbox"/> Painful or Difficult Urination <input type="checkbox"/> Frequency <input type="checkbox"/> Excessive Urination at Night <input type="checkbox"/> Post Void Dribbling <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Urgency <p>INTEGUMENT/SKIN</p> <input type="checkbox"/> Pigmentation Changes <input type="checkbox"/> Skin Dryness <input type="checkbox"/> Rash <input type="checkbox"/> New Skin Lesions <input type="checkbox"/> Changes to Existing Skin Lesions/Moles <input type="checkbox"/> Hair Growth Change <p>NEUROLOGIC</p> <input type="checkbox"/> Tremors <input type="checkbox"/> Speech Difficulties <input type="checkbox"/> Paralysis <input type="checkbox"/> Tingling or Numbness <input type="checkbox"/> Seizures <input type="checkbox"/> Muscular Weakness	<p>MUSCULOSKELETAL</p> <input type="checkbox"/> Muscle Cramps <input type="checkbox"/> Nocturnal Leg Cramps <input type="checkbox"/> Joint Pain <input type="checkbox"/> Joint Swelling <p>ENDOCRINE</p> <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Drinking More Fluids <input type="checkbox"/> Excessive Urination <input type="checkbox"/> Excessive or Abnormal Thirst <input type="checkbox"/> Excessive Hair Growth <input type="checkbox"/> Hot Flashes <p>HEMA-LYMPH</p> <input type="checkbox"/> Lymph Node Enlargement <input type="checkbox"/> Easy Bleeding <input type="checkbox"/> Easy Bruising <p>ALLERGIC-IMMUNO</p> <input type="checkbox"/> Sinus Allergy <input type="checkbox"/> Hay Fever <input type="checkbox"/> Allergic Dermatitis
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I certify these two pages to be accurate and current to the best of my knowledge (Please sign and date below)

Patient Signature: _____ Date: _____

**CONSENT FOR DISCLOSURE TO FAMILY MEMBER
AND/OR PERSONAL REPRESENTATIVE**

NORTH ATLANTA ENDOCRINOLOGY AND DIABETES, P.C.

I have agreed to let certain individuals participate in discussions and decisions related to my medical care, Therefore, I hereby give my permission for North Atlanta Endocrinology and Diabetes, P.C. to disclose my personal medical information to the following individual(s):

Name: _____ Relationship to patient: _____

Telephone #: _____

Name: _____ Relationship to patient: _____

Telephone #: _____

Name: _____ Relationship to patient: _____

Telephone #: _____

Conditions for Disclosure (Check the item(s) that apply):

- The practice may disclose my personal health information to the individual(s) above **only in my presence**

OR

- The practice may disclose my medical information to the individual(s) above in discussions in my presence and when I am not physically present, including disclosures by telephone, facsimile or e-mail or regular mail,
- The practice has my permission to leave detailed messages about my personal health on my home answering machine and/or my cellular voicemail or on the voicemails of any of the individuals listed above.
- Other conditions of disclosure: _____
- _____

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Signature: _____ **Date:** _____

Print Name of Patient: _____

Witnessed By: _____ **NAED Employee**

Witness Date: _____

North Atlanta Endocrinology & Diabetes, P.C.

Diabetes Self-Management Education

ASSESSMENT FORM

Name: _____ Date: _____
Date of Birth: ____/____/____ Gender: F ____ M ____
Marital Status: Single ____ Married ____ Divorced ____ Widowed ____
Ethnic Background: White/Caucasian ____ Black/ African American ____ Hispanic ____
Native American ____ Middle Eastern ____ Other: _____
What is your language preference? English ____ Other: _____
What is the last grade of school completed? Grade school ____ High school ____ College ____
Email address: _____ (For diabetes education/follow-up ONLY)

1. What type of diabetes do you have? Type 1 ____ Type 2 ____ Gestational ____
Pre-Diabetes ____ Do not know ____
2. When were you diagnosed with diabetes? _____
List of relatives with diabetes _____
3. Do you take diabetes medications? Yes ____ No ____ (If yes check all that apply below)
Diabetes pills ____ Insulin injections ____ Byetta injections ____ Victoza injections ____
Symlin injections ____ Combination of pills and injections ____
4. Do you have: High blood pressure ____ High cholesterol ____ Nerve damage ____
Kidney disease ____ Heart disease ____ Lung disease ____ Eye disease ____
Depression ____
5. Have you attended a diabetes education program in the past? Yes ____ No ____
How long ago? _____
7. From whom do you get support for your diabetes? Family ____ Co-workers ____
Healthcare providers ____ Support group ____ No-one ____

8. Do you have a meal plan for diabetes? Yes ____ No ____
If yes, please describe: _____
About how often do you use this meal plan? Never ____ Seldom ____ Sometimes ____
Usually ____ Always ____
Do you read and use food labels as a dietary guide? Yes ____ No ____
Do you have any dietary restrictions: Salt ____ Fat ____ Fluid ____ Other: _____
None ____
Give a sample of your meals for a typical day:
Time: _____ Breakfast: _____
Time: _____ Lunch: _____
Time: _____ Dinner: _____
Time: _____ Snack: _____
9. Do you do your own food shopping? Yes ____ No ____
Cook your own meals? Yes ____ No ____
How often do you eat out? _____
10. Do you drink alcohol? Yes ____ No ____ Occasionally ____ How many drinks per week ____

11. Do you use tobacco? Yes No Quit: _____
12. Do you exercise? Yes No Type _____ How often _____
13. Do you check your blood sugars? Yes No How often? Once a day _____
 2 or more/day _____ 1 or more/week _____ Occasionally _____
 What is your blood sugar range: Before meals: _____ to _____ After Meals: _____ to _____
14. In the last month, how often have you had a low blood sugar reaction? Never Once
 One or more times/week _____ What are your symptoms? _____
15. Can you tell when your blood sugar is too high? Yes No
16. In the past 12 months which of these test/procedures you have had: Dilated eye exam _____
 Urine test for protein _____ Foot exam _____ Dental exam _____ Blood Pressure _____
 Weight _____ Cholesterol _____ HgA1c _____ Flu Shot _____ Pneumonia Shot _____

17. In your own words, what is diabetes? _____
18. How do you learn best? Listening Reading Observing Doing
19. Do you have any difficulty with? Hearing Seeing Reading Speaking

20. Do you have any cultural or religious practices or beliefs that influence how you care for you diabetes? Yes No Please describe: _____
21. Do you feel good about your general health? Yes No Not sure
 Does diabetes interfere with other aspects of your life? Yes No
 How is your level of stress? High Low No stress
22. How do you handle stress? _____
 Do you struggle with making changes in your life to care for your diabetes: Yes No
23. What concerns you most about your diabetes? _____
24. What is hardest for you in caring for you diabetes? _____
25. What are you most interested in learning from your diabetes education sessions? _____

For Women Only

2. Pregnancy and Fertility:
- Are you: Pre-menopausal Menopausal Post-Menopausal N/A
- Are you pregnant? Y N When are you expecting? _____
- Are you planning on becoming pregnant? Y N
- Are you aware of the impact of diabetes on pregnancy? Y N
- Are you using birth control? Y N N/A

Please do not write below this line

Clinician Assessment Summary:

Education Needs/education plan for patient:

Diabetes Disease Process	Using Medications	Psychosocial Adjustment
Nutritional Management	Physical Activity	Preventing Acute Complications
Preventing Chronic Complications	Behavior Change Strategies	Risk Reduction Strategies
Monitoring		

Date: _____ Clinician Signature: _____

North Atlanta Endocrinology and Diabetes

Lawrenceville | Bethlehem

Patient Acknowledgment

Continuous Glucose Monitor (CGM) Interpretation — CPT Code 95251

What Is a Continuous Glucose Monitor (CGM)?

A CGM is a small wearable device that automatically tracks your blood sugar around the clock using a tiny sensor placed just under the skin — no routine finger sticks are required. It sends glucose readings to a receiver or smartphone every few minutes, 24 hours a day, revealing patterns, highs, lows, and trends that a traditional finger stick can never capture. This information helps prevent dangerous blood sugar episodes and guides better decisions about food, activity, and medication.

Because a CGM generates a large volume of complex data, simply wearing the device is not enough. That data must be reviewed, analyzed, and interpreted by your provider to be clinically useful — and that is precisely what CPT code 95251 represents.

This applies whether you are a new patient already using a CGM device prescribed elsewhere, or a patient for whom we are prescribing one for the first time.

What Is CPT Code 95251?

CPT 95251 is the billing code for the formal analysis, interpretation, and written clinical report of your CGM data. It is a professional medical service — separate from your office visit — performed by your provider each time your CGM data is reviewed.

Why Must This Be Billed?

CGM data interpretation is the current standard of care in Endocrinology, recognized by the American Association of Clinical Endocrinology (AACE) and the American Diabetes Association (ADA) as an essential component of diabetes management. Your provider is producing a documented clinical report — not simply glancing at numbers — that directly guide your treatment plan.

This service is governed by American Medical Association coding standards and federal insurance compliance requirements. It cannot be waived, omitted, or absorbed into your office visit.

IMPORTANT: Your provider will not prescribe or continue to prescribe a CGM device without performing and billing this interpretation service. There are no exceptions.

Why Might I Have a Balance?

Coverage for CPT 95251 varies by plan. Some insurers cover it in full; others apply it to your deductible or limit coverage frequency. We are required to bill this code regardless of how your plan processes it, and any remaining balance is your responsibility under your insurance contract.

By signing below, I confirm that I have read and understand this notice. I acknowledge that CPT 95251 will be billed when my CGM data is interpreted by my provider, that this service is required and cannot be waived, and that my financial responsibility will be determined by the terms of my insurance plan.

Patient Name (print): _____

Date of Birth: _____

Patient Signature: _____

Date: _____

OFFICE POLICIES AND PROCEDURES FOR NORTH ATLANTA ENDOCRINOLOGY & DIABETES

Thank you for choosing North Atlanta Endocrinology & Diabetes for your healthcare needs. We are dedicated to providing excellent treatment and want you to have a full understanding of our office policies. Please acknowledge your agreement to these policies by initialing beside each statement.

____ Payment for services rendered including co-payments, coinsurance or deductibles **are due at the time of service. Furthermore, if your deductible has not been met, we will collect \$100.00 upon check in to go towards any balance you may owe after your insurance has processed the claim.** We accept cash, check, debit and all major credit cards. If you are unable to pay on the date of your appointment you will be asked to reschedule.

____ We do not hold or accept postdated checks. Also, if funds are not available in your account and the check is returned to us as an NSF (or for any other reason), **you will be assessed a \$37.00 service fee plus the cost of the original check.** All checks returned to our office are sent to an outside agency (Envision) for collection. **After one NSF we will no longer accept checks from the patient.** Going forward, all fees must be paid by cash or with credit card.

____ While we will gladly file all charges to your insurance, **please remember that a contract exists between you and the insurance company, not with our office.** If your insurance company does not pay our office within a reasonable time period, **we will have no choice but to seek payment from the patient.**

____ If your insurance requires a referral from your Primary Care Physician, it is **YOUR RESPONSIBILITY** to obtain that referral. We will not be able to see you without a current referral on file. However, if you choose not to obtain a referral, you may become a self-pay patient for that visit only. You will be given a 60% discount on all Office visit charges and a 50% discount on labs and procedures (Ultrasound, Bone Density, etc..). **Payment will be expected on date of service. In addition, our office will consider the claim closed and will not file it at any later date.**

____ We attempt to keep our office fully educated on the most recent changes with insurance coverage. However, we cannot know each patient's individual policy. **Patients will need to contact their insurance providers directly** if there is a question regarding coverage for any procedures performed in our office. **This includes the application, download and removal of the continuous glucose monitoring system (CGMS) as some insurance companies may apply an additional copay for this service.** We will obtain precertification if necessary.

____ Please provide 24-hour notice if you must cancel or reschedule an appointment. If we are not given this adequate amount of time, **a \$25.00 NO SHOW fee will be charged to your account and must be paid prior to your next appointment.** If a patient acquires 3 "NO SHOWS", they will be subject to dismissal from the practice.

Name

Birthdate

Date

____ Any patient who comes into the office **(without an appointment)** requesting to see a member of our clinical staff **may incur a \$30.00 minimal office visit charge billed to their insurance.** Further, if it is determined that you need to see a physician, physician's assistant or nurse practitioner, a larger fee for an office visit will apply. The patient will be responsible for co-payments, deductibles and coinsurance amounts.

____ We certainly understand that personal health issues can affect your overall sense of wellbeing and as such, might cause a patient to feel very distressed. However, **we will not accept abusive or threatening behavior directed at our staff or providers.** Any such behavior will result in immediate dismissal from this practice. Please address any complaints or concerns in a calm manner to a member of our management team.

____ **ePrescribing** allows your physician the ability to electronically send accurate, error free and understandable prescriptions directly to a pharmacy. By initialing, **you are giving consent** for North Atlanta Endocrinology & Diabetes to request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

____ There is a fee for all FMLA, school/work, medication and any other miscellaneous forms required by a physician to complete and sign. **Completion of the form will be \$25.00 for the first page and \$5.00 for each additional page.**

____ A flat fee of \$25.00 will need to be collected for any medication **that requires our office to provide a prior authorization** to the patient's insurance company.

____ **Our physicians WILL NOT sign off on medical clearances required by employers. Examples: DOT, pilot, bus driver, etc....**

I have read and fully understand the policies and procedures of North Atlanta Endocrinology & Diabetes and I agree to the terms explained.

Signature of Patient

Date

Name

Birthdate



NORTH ATLANTA ENDOCRINOLOGY AND DIABETES, P.C.

OFFICE POLICY FOR YOUR INSURANCE PLAN

At North Atlanta Endocrinology & Diabetes our primary goal is to fulfill the patient's needs to our utmost ability. In accordance with that desire, we have become contractual providers with as many insurance plans as possible.

As a result of participating with so many networks, it is impossible for our staff to know each and every condition set forth by each plan. In some cases, even the same insurance company has several different plans with individual prerequisites that vary.

We certainly try to stay abreast of any changes or necessities put forth by your insurance company but we do not assume responsibility when your claims are denied due to guidelines within an individual plan that we have not been made aware of. If there are certain restrictions or limitations, we depend on the patient to inform us of any such requirements, otherwise you will be responsible for the balance. Furthermore, failure to provide accurate information or correct insurance within your plans timely filing limits will leave us no choice but to bill the patient.

As new insurance plans are made available on the market, be sure that we will always try to negotiate contracts so that we may offer our services to as many patients as possible. With due diligence on your part, we can ensure that your benefits will be utilized effectively.

Date : _____

Print Name: _____

Signature: _____

NORTH ATLANTA ENDOCRINOLOGY AND DIABETES, P.C.
771 OLD NORCROSS ROAD, SUITE 200
LAWRENCEVILLE, GA 30046
770-339-1387

ACKNOWLEDGEMENT FORM FOR PRIVACY NOTICE

I acknowledge that North Atlanta Endocrinology and Diabetes, P.C. has informed me of the Privacy Notice that is a requirement of the Health Insurance Portability and Accountability Act (HIPAA). I understand that this notice is posted in the office for me to fully review. I also understand that I may ask for a written copy of this notice for my own personal records.

Signed by patient or legal guardian

Print Name

Date of Birth

Date