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.

North Atlanta
NAED
Endocrinology & Diabetes

David B. Arkin, MD
A. Ola Odugbesan, MD
David A. Shore, MD
Aparna Mahakala, MD
Peter Lu, MD
Ketan G. Goswami, MD

Hyacinth Thomas, MSN, FNP-BC, CDE
Rachel Nejem, MSN, RN, NP-C
Brian Murrell, PA-C
Tracy Perry, FNP-C

AS A REMINDER...

You are scheduled to see ____________________ at __________ on ____________

in the ☐ Lawrenceville Office ☐ Bethlehem Office

Phone 770-339-1387

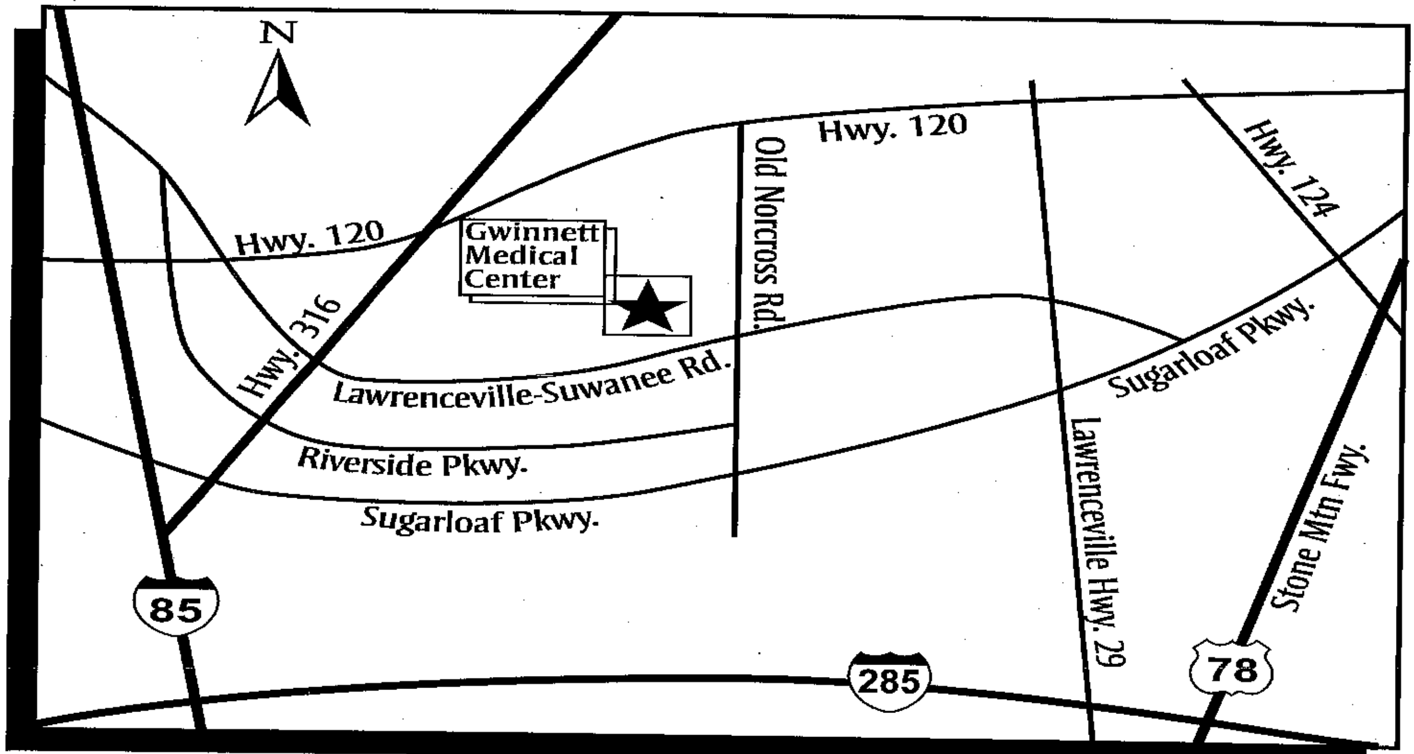
PLEASE BRING...

☑ 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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AS A REMINDER...

You are scheduled to see ______________________ at __________ on ______________

in the ❑ Lawrenceville Office ❑ Bethlehem Office Phone 770-339-1387

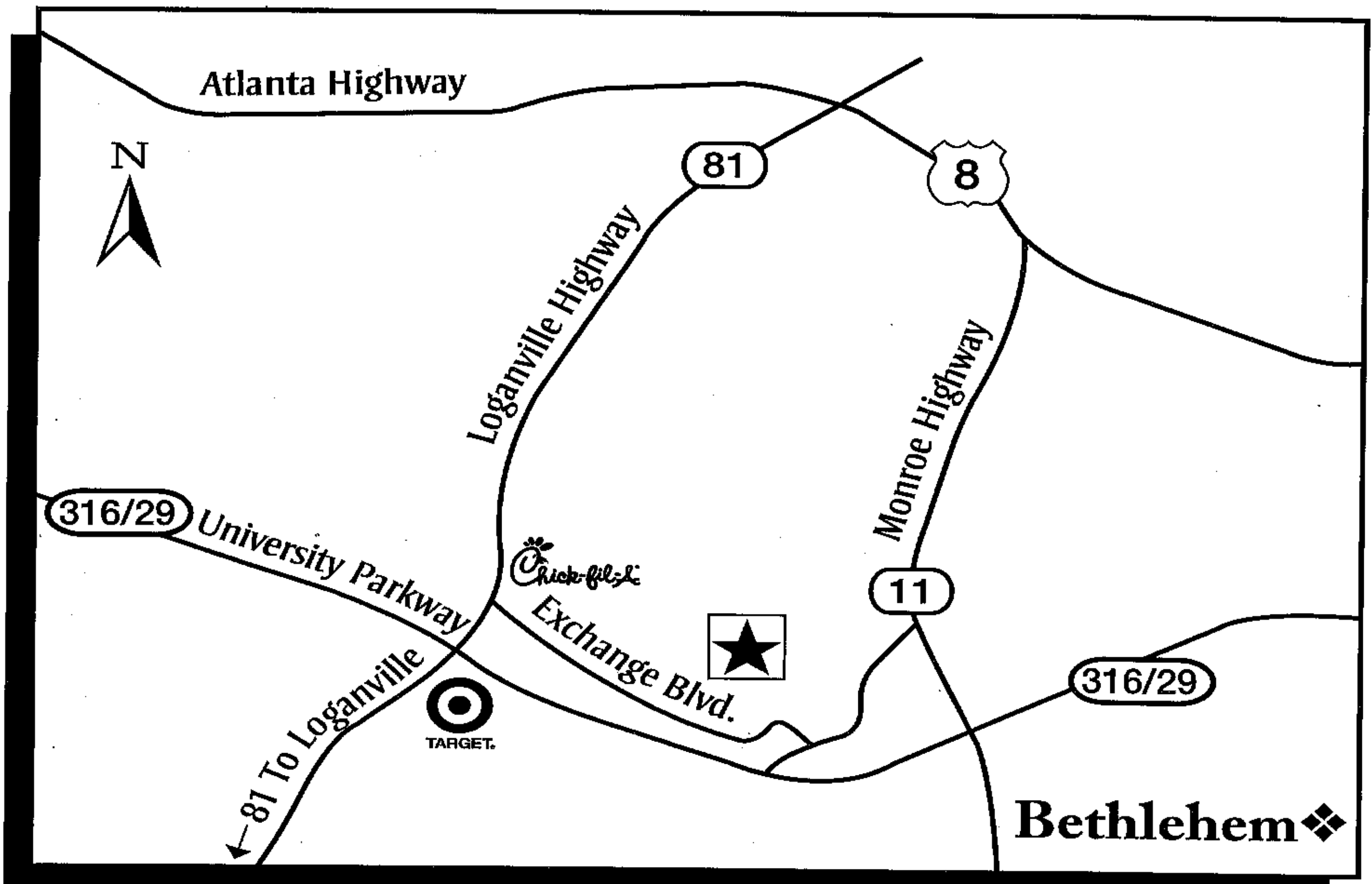
PLEASE BRING...

☑ 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

BETHLEHEM OFFICE

426 Exchange Boulevard, Building C, Suite 300, Bethlehem, GA 30620



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Directions to Bethlehem Office: We are located at 426 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 is .5 miles on right.

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 is .5 miles on right.

www.northatlantaendo.com

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: Please Circle

American/Indian/Alaska Asian White

Black/African American Nat Hawaiian/Pacific Islander Other Race

Are you of Hispanic/ Latino descent? YES / NO

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: ____________

North Atlanta
NAE&D
Endocrinology
& Diabetes, P.C.

Date: ____________

PERSONAL MEDICAL HISTORY

Note: This is a confidential report of your medical history.
Information contained here will be released only if you have authorized us to do so.

Last Name: ____________ First Name: ____________ Middle Initial: ____

Date of Birth: ___ /___ /___ Sex: ❑ Female ❑ Male Marital Status: ____

Preferred Pharmacy: ____________ **Pharmacy Phone #:** ____________

Pharmacy Address: ____________

PCP: ____________ **Referring Doctor:** ____________

Past Medical History:
Check any conditions you have had:

- ❑ Abnormal EKG
- ❑ Anemia
- ❑ Angina Pectoris
- ❑ Asthma
- ❑ Bone Disease
- ❑ Breast Lump
- ❑ Cancer
  Type: ____________
- ❑ Coronary Artery Disease (Heart Disease)
- ❑ Decreased Libido
- ❑ Depression
- ❑ Diabetes Type I
- ❑ Diabetes Type II
- ❑ Dyslipidemia (High Cholesterol)
- ❑ Emphysema
- ❑ Endocrine Disorder
- ❑ Gallbladder Disease
- ❑ Heart Attack
- ❑ Hepatitis
- ❑ Hypertension (High Blood Pressure)
- ❑ Hyperthyroidism (Overactive Thyroid)
- ❑ Hypothyroidism (Underactive Thyroid)
- ❑ Impotence/ED
- ❑ Infertility
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Meningitis
- ❑ Mental Illness
- ❑ Migraines
- ❑ Nipple Discharge
- ❑ Osteoporosis
- ❑ Phlebitis
- ❑ Postmenopausal Bleeding
- ❑ Seizures
- ❑ Serious Injury
- ❑ Stomach Ulcer
- ❑ Stroke
- ❑ Thyroid Cancer
- ❑ Thyroid Nodule
- ❑ Tuberculosis

Have you ever had External Beam Neck Radiation?
❑ No ❑ Yes Date: ____________

Other major diseases: ____________

____

Health Maintenance: Fill in all that apply

Date of last eye exam: ____________

Date of last prostate exam: ____________

Date of last PAP test: ____________

Previous mammogram: ____________

Glasses or contacts? ❑ No ❑ Yes ❑ Both

Past Surgical History:

Have you ever had surgery? ❑ Yes ❑ No

If yes, please list:

Type: ____________ Year: ______

Type: ____________ Year: ______

Type: ____________ Year: ______

Recent Hospitalizations: ____________

____

Medications:

List all medicines and supplements you take:

Medicine or Supplement	How much?	How often?

Allergies:

Are you allergic to any medications? ❑ Yes ❑ No

Please list: ____________

Are you allergic to latex? ❑ Yes ❑ No

Are you allergic to any foods? ❑ Yes ❑ No

Please list: ____________

____

Family History: Parents, Grandparents, Brothers, Sisters, Children, Aunts and Uncles			
Yes	**No**	**Disease:**	**Relative(s):**
❑	❑	Asthma	______
❑	❑	Cancer	______
❑	❑	Diabetes	______
❑	❑	Heart Disease	______
❑	❑	High Blood Pressure	______
❑	❑	Kidney Disease	______
❑	❑	Mental Illness	______
❑	❑	Other Glandular Disease	______
❑	❑	Stomach Ulcers	______
❑	❑	Stroke	______
❑	❑	Thyroid Disease/ Goiter	______
❑	❑	Tuberculosis	______

Social History:

Do you use alcohol?
❑ Never ❑ Former ❑ Some Days ❑ Everyday

Do you drink caffeinated beverages?
❑ Yes ❑ No

Have you ever smoked?
❑ Never ❑ Former ❑ Some Days ❑ Everyday
If yes, how many years have you smoked? ______
Packs per day? ______

How often do you exercise?
❑ Never ❑ 1x per wk ❑ 2-3x per wk ❑ 4+x per wk

Are your parents living? ❑ Mom ❑ Dad
How many siblings do you have? ______
How many children do you have? ______
Highest level of education? ______
Occupation: ______

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

CONSTITUTIONAL
❑ Change in weight of more than 10 lbs.
❑ Night Sweats
❑ Fatigue

EYES
❑ Trouble with Vision
❑ Changes in Vision
❑ Double Vision
❑ Blurred Vision

HEAD ENT
❑ Changes in Hearing
❑ Hoarseness
❑ Headaches

BREASTS
❑ Changes in Skin
❑ Masses
❑ Nipple Discharge

PSYCHIATRIC
❑ Anxiety
❑ Depression
❑ Difficulty Breathing

CARDIOVASCULAR
❑ Palpitations
❑ Chest Pain
❑ Difficulty Breathing on Exertion
❑ Lower Extremity Swelling
❑ Loss of Consciousness

RESPIRATORY
❑ Chronic Cough
❑ Coughing Blood
❑ Shortness of Breath
❑ Wheezing
❑ Difficulty Breathing

GASTROINTESTINAL
❑ Difficulty Swallowing
❑ Reflux
❑ Nausea
❑ Vomiting
❑ Vomiting Blood
❑ Diarrhea
❑ Constipation
❑ Blood in Stools
❑ Changes in Bowel Habits

GENITOURINARY
❑ Painful or Difficult Urination
❑ Frequency
❑ Excessive Urination at Night
❑ Post Void Dribbling
❑ Blood in Urine
❑ Urgency

INTEGUMENT/SKIN
❑ Pigmentation Changes
❑ Skin Dryness
❑ Rash
❑ New Skin Lesions
❑ Changes to Existing Skin Lesions/Moles
❑ Hair Growth Change

NEUROLOGIC
❑ Tremors
❑ Speech Difficulties
❑ Paralysis
❑ Tingling or Numbness
❑ Seizures
❑ Muscular Weakness

MUSCULOSKELETAL
❑ Muscle Cramps
❑ Nocturnal Leg Cramps
❑ Joint Pain
❑ Joint Swelling

ENDOCRINE
❑ Cold Intolerance
❑ Heat Intolerance
❑ Drinking More Fluids
❑ Excessive Urination
❑ Excessive or Abnormal Thirst
❑ Excessive Hair Growth
❑ Hot Flashes

HEMA-LYMPH
❑ Lymph Node Enlargement
❑ Easy Bleeding
❑ Easy Bruising

ALLERGIC-IMMUNO
❑ Sinus Allergy
❑ Hay Fever
❑ Allergic Dermatitis

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 I _____ 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: ____

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 $75.00 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 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 the 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 sign an insurance waiver and become a self-pay patient for that visit only. You will be given a 55% 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 insurances may apply an additional copay for this service**. We will obtain pre-certification 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 fashion 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 disability, 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