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**

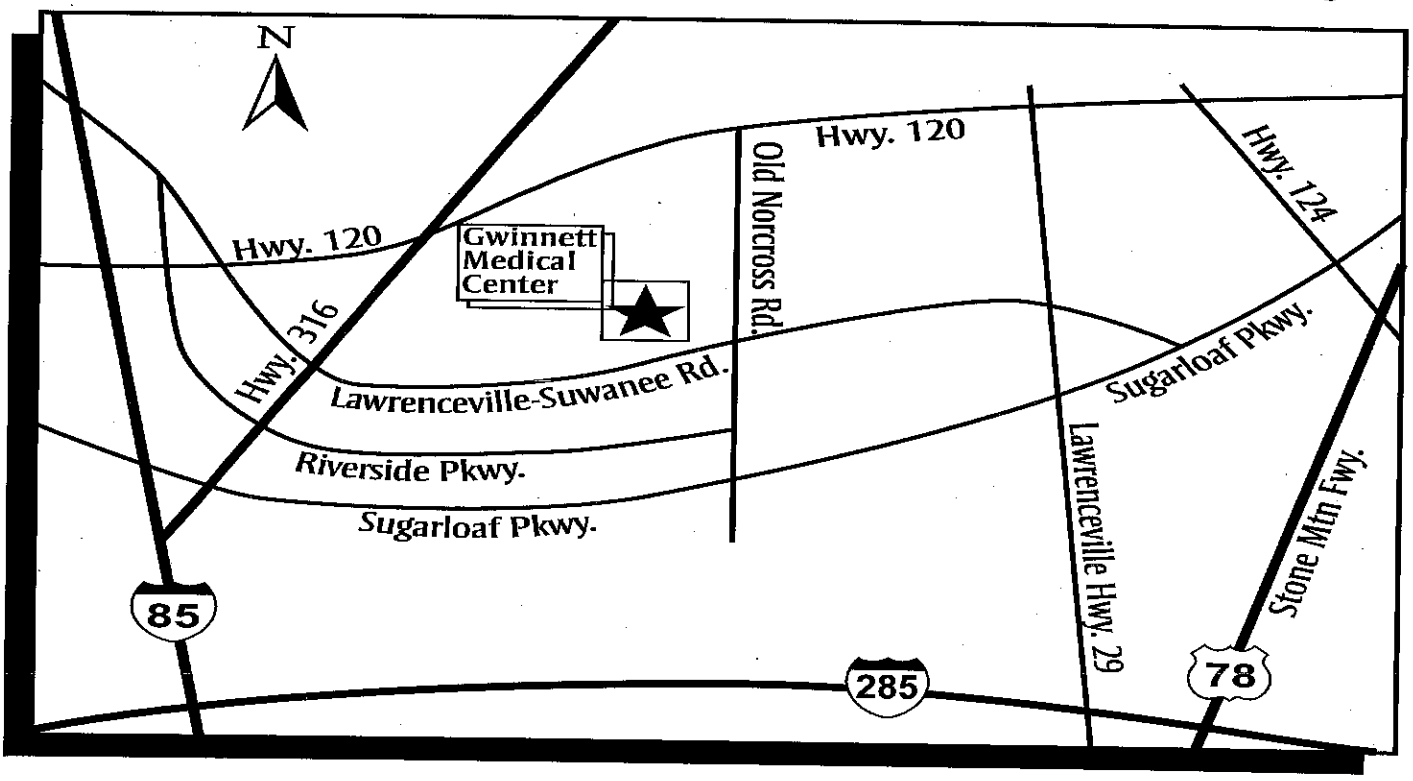
PLEASE BRING...

☑ 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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You are scheduled to see _____ at _____ on _____

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

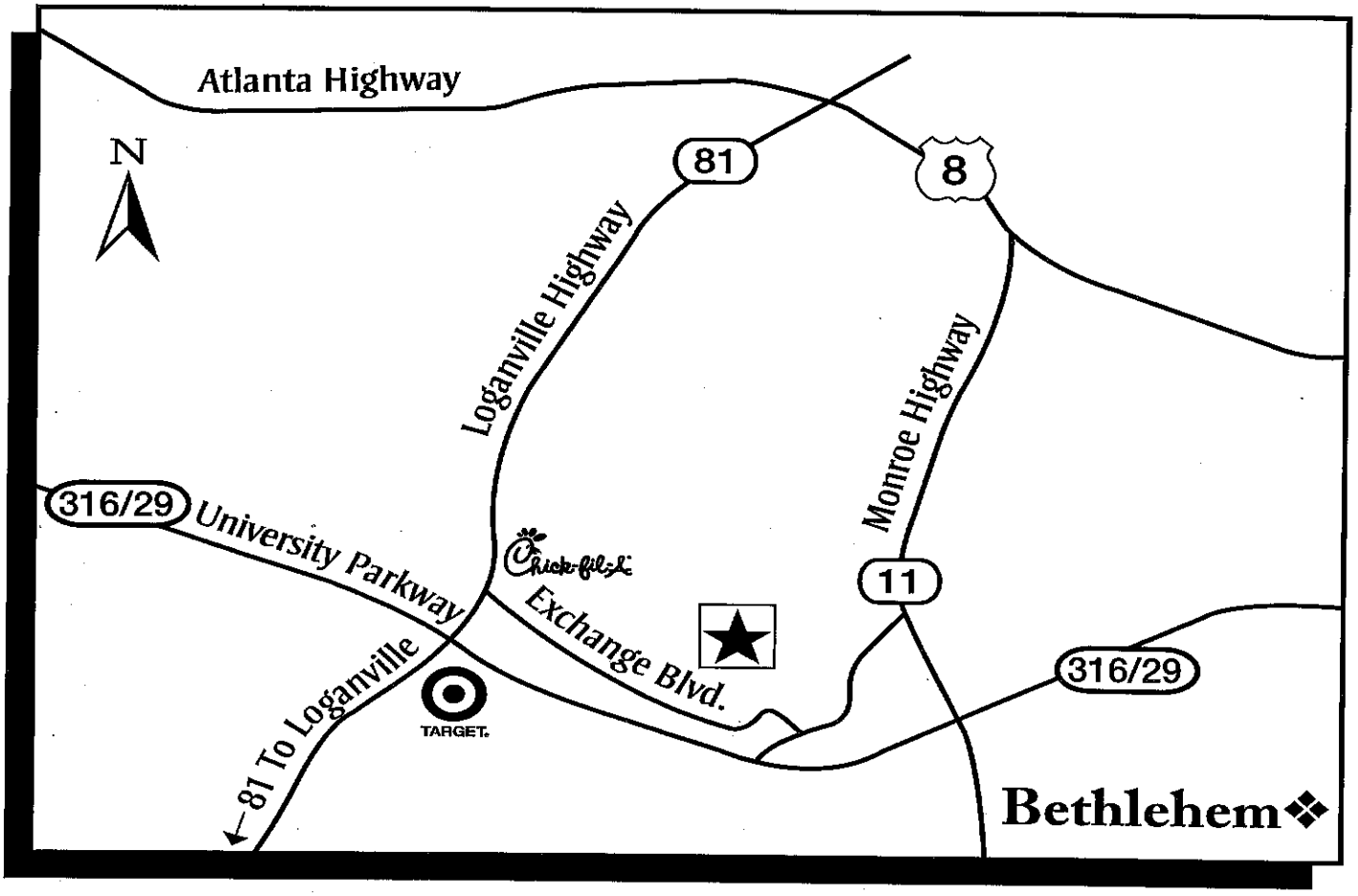
PLEASE BRING...

☑ 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



©MBC

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:** _____

Race: Please Circle

Federal regulations now require that we collect the following demographic information below

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 $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
NAED
Endocrinology & Diabetes

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