CMED

CENTER FOR MEDICINE, ENDOCRINOLOGY
AND DIABETES, LLC

Dear

It is a pleasure to welcome you to our practice of Internal Medicine and Endocrinology. Thank you for choosing us to provide a program of comprehensive medical care for you. We believe that our primary responsibility is to provide our patients with the highest quality services and we appreciate your confidence in selecting the Center for Medicine Endocrinology and Diabetes.

We are sending you this letter to confirm an appointment with _____

on _____at_____am/pm. Please complete the the enclosed forms and bring them with you to your first appointment.

DO NOT MAIL THE FORMS BACK TO US. BRING THEM TO YOUR APPOINTMENT.

Please arrive 15 minutes prior to your appointment time in order to complete the check-in process. Make sure to bring your insurance card along with your co-pay. We accept cash ,check and credit cards.

We would also request that you fast for your appointment. Please refer to the following guidelines:

AM APPOINTMENTS -- FAST FROM AFTER MIDNIGHT
PM APPOINTMENTS -- FAST FOR 4 HOURS

DIABETIC PATIENTS NEED ONLY FAST FOR 2 HOURS PRIOR TO YOUR APPOINTMENT

DURING THE FASTING PERIOD, YOU MAY HAVE WATER,BLACK COFFEE OR TEA WITH ARTIFICIAL SWEETENER OR ANY TYPE OF DIET SODA OR DRINK.

IN ADDITION WE REQUEST THAT YOU LEAVE OFF ANY LOTION OR STRONG PERFUME ON THE DAY OF YOUR APPOINTMENT.

PLEASE FEEL FREE TO CALL WITH ANY QUESTIONS.

MELINDA 404-250-6722

5667 Peachtree Dunwoody Road • Suite 150 • Atlanta, Georgia 30342 • (404) 256-0775

Center For Medicine, Endocrinology and Diabetes, LLC

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name?		If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:	
❑ Yes	❑ No			/ /		❑ M	❑ F

Street address:	City:	State:	Zip:

Social Security #	Home phone:	Cell phone:

Occupation:	Employer:	Employer phone #: ( )

Email Address:

Doctor Who Referred You:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Address (if different):	Home phone #: ( )

Are you covered by insurance?	❑ Yes	❑ No	Please indicate primary Insurance:

Subscriber's name:	Subscriber's S.S. #:	Birth date:	Group no.:	Policy no.:	Co-payment:
		/ /			$

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Subscriber birth Date:	Group no.:	Policy no.:
		/ /		

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

	Patient/Guardian signature		*Date*

CMED

CENTER FOR MEDICINE, ENDOCRINOLOGY AND DIABETES, LLC

MEDICAL HISTORY QUESTIONNAIRE

Date _____ Patient name _____ Age _____

Date of Birth _____ Referring physician _____

MEDICATIONS: List all your medications, including over the counter, vitamins, food supplements. (If there is not enough room, please use the available space on the 2nd page.)

NAME OF DRUG	DOSAGE	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

LIST YOUR DRUG ALLERGIES WITH SYMPTOMS YOU EXPERIENCED:

_____

_____

_____

LIST ALL HOSPITALIZATIONS, SURGERIES, ACCIDENTS/INJURIES: (If there is not enough room, please use the available space on the 2nd page)

DATE	DIAGNOSIS	LOCATION

Social History

Place of birth _____
Marital Status (duration and number of marriages if applicable) _____
Number of children and ages _____
Highest level of education completed and degree _____
Occupations _____
Hazardous exposures at work or at home _____
Pets and other animals exposed to _____
Travel outside U.S. in past 5 years _____
Tobacco usage (current or past) _____ Amount/Duration _____ If applicable, date of cessation _____
Caffeine usage _____ How much per day _____
Alcohol usage _____ How much per week _____
Recreational drug usage _____ Which type and how much per week _____
Exercise: How many times per week _____ Type of exercise _____ How many minutes _____

Family History

Do any of your close relatives have the following conditions?

	Yes	No	Relatives
Heart disease	_____	_____	_____
High blood pressure	_____	_____	_____
Stroke	_____	_____	_____
High Cholesterol	_____	_____	_____
Diabetes	_____	_____	_____
Thyroid disease	_____	_____	_____
Kidney stones	_____	_____	_____
Osteoporosis	_____	_____	_____
Mental illness	_____	_____	_____
Bleeding disorder	_____	_____	_____
Anemia	_____	_____	_____
Colon cancer	_____	_____	_____
Ovarian cancer	_____	_____	_____
Breast cancer	_____	_____	_____
Prostate cancer	_____	_____	_____
Alcoholism	_____	_____	_____

Immunizations
(in past 10 years)
(Put Date of Last Shot)

Measles/MMR _____
Tetanus/DPT/DT _____
Hepatitis _____
Flu _____
Pneumonia _____
Other _____

List the following information on your immediate family:

Family member	Age	If not living, age at death	Cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers/Sisters	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

_____
_____
_____
_____

REVIEW OF SYSTEMS

Please circle any of the following symptoms which you have experienced.

SYMPTOM

General

Fever
Fatigue
Weight change>10lbs.
Difficulty Sleeping
Mumps
Measles
HIV infection
Blood transfusion
Breast implants
Alcoholism
Chills
Sweats
Appetite Change
Anemia
Excessive daytime sleepiness

Pulmonary

Cough
Coughing up blood
Coughing up mucous
Bronchitis
Pneumonia
Pleurisy
Wheezing
Asthma
Positive TB skin test
Tuberculosis
Previous chest x ray _____ (date)

Musculoskeletal

Pain in muscles/joints
Joint swelling
Muscle cramps
Arthritis
Joint stiffness
Back pain
Handicapped
Gout
Previous bone density _____ (date)

SYMPTOM

Eyes, Ears, Nose, Throat

Sinusitis
Change in vision
Color blindness
Night blindness
Blurred vision
Double vision
Peripheral vision change
Ear pain
Difficulty hearing
Noises in ears
Previous eye exam _____ (date)
Previous dental exam _____ (date)
Hayfever/Allergies
Dizziness/Vertigo
Snoring

Cardiovascular

Palpitations
High blood pressure
Chest pain
Heart disease
Heart murmur
Mitral valve prolapse
Shortness of breath
Swelling
Blue fingers or toes
Phlebitis/blood clots
Leg pain with walking
Previous EKG _____ (date)
Previous treadmill test _____ (date)
Rheumatic Fever
Pacemaker
Passing out

Reproductive (male)

Penile discharge
Penile pain
Lumps in testicles
Painful testicles
Large prostate
Prostatitis
Prostate cancer
Impotence
Cannot have erections
Lack of sexual desire
Cannot have orgasms
Sexually transmitted diseases
Hernia
Last PSA _____ (date) and level _____

SYMPTOM

Skin

Color/texture change
Change in hair or nails
Rashes
Itching
Easily bruised
Hives
Frequent skin infections
Eczema
Psoriasis
Skin Cancer

Urinary

Excessive urination
Urination at night
Pain with urination
Urge to urinate
Urinary tract infection
Kidney stones
Leakage of urine
Change in urine stream
Trouble starting stream
Blood in urine
Brown urine

Neurological

Weakness
Stroke
Paralysis
Difficulty speaking
Seizures
Headaches
Change in sensation
Numbness, tingling
Feeling faint
Change in handwriting
Tremor
Anxiety
Phobias
Hallucinations
Depression
Psychiatric treatment
Suicide attempt
Thoughts of suicide
Physical/Sexual abuse
Memory Loss

Gastrointestinal

Food intolerance
Problems with teeth/gums
Abnormal taste
Sore tongue
Trouble swallowing
Heartburn
Stomach pain
Excessive belching
Bloating
Nausea
Vomiting
Vomiting blood
Ulcers
Hepatitis / Jaundice
Gallbladder disease
Hemorrhoids
Pancreatitis
Inflammatory Bowel
Spastic colon
Change in stool
Black stool
Blood in stool
Diarrhea
Constipation
Excessive gas
Lactose intolerance
Reflux
Hiatal Hernia
Previous colonoscopy/sigmoidoscopy _____ (date)

Endocrine

Ring size change
Shoe size change
Abnormal sweating
Change in appetite
Breast milk
Head/neck irradiation
Thyroid disease
Goiter/enlarge thyroid
Cold intolerance
Heat intolerance
Trouble losing weight
Execessive hair growth
Loss of hair
Acne
Breast enlargement
Execessive hunger
Excessive thirst
Excessive urination
Sugar in the urine
Diabetes
High blood calcium
Low blood calcium
Osteoporosis
Gestational Diabetes

Reproductive (female)

Age you first started your period _____

Date of your last menstrual period _____

How many pregnancies have you had? (Including unsuccessful and successful pregnancies)_____

Weight(s) of newborns? _____

How many pregnancies went to term?_____

How many pregnancies were premature?_____

How many miscarriages/abortions have you had?_____

Any complications with any pregnancy_____ _____

Date of hysterectomy _____Were your ovaries also removed? _____

Last Pap test _____ Last Mammogram _____

(Circle any of the following, which are chronic or recurrent problems)

Change in periods
Hot flashes/flushes
Sweats
Vaginal dryness
Vaginal infections
PMS
Pain with intercourse
Infertility
Change in sexual desire
Sexually transmitted disease
Breast lumps
Breast pain
Breast discharge
Breast cancer
Wetting of pants

NOTICE OF PRIVACY PRACTICES

CMED, LLC
5667 Peachtree Dunwoody Road
Suite 150
Atlanta, Georgia 30342

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Sybil Lawrence, the Practice Privacy Officer.

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION:

Information about you and your health is personal. We are committed to protecting your health information. We create a record of the care and services you receive at our practice, as well as records regarding payment for those services. We need these records to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our medical practice.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and our obligations regarding the use and disclosure of medical information.

HIPAA (Health Insurance Portability and Accountability Act) requires us to make sure that medical information which identifies you is kept private; and that we give you this notice of our privacy practices with respect to medical information about you.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures, we will explain what we mean. All of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other personnel who are involved in taking care of you. Our practice also may share medical information about you in order to coordinate the different things you need, such as prescriptions and lab work.

For Payment: We may use and disclose health information about you so the treatment and services you receive at our practice may be billed, and that payment may be collected from you, an insurance company or another third party. We may need to disclose some of your health information about services you received at our practice so that your health plan will pay us for the services.

For Health Care Operations: We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run our practice and make sure all patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you.

We may use a sign-in sheet at the registration desk and we may call you by name in the waiting room. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We will share your protected health information with business associates that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use and disclosure of your information, we will have a contract to protect your privacy.

Individuals Involve In Your Care or Payment for Your Care: We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends of your condition.

As Required By Law: We will disclose medical information about you when required to do so by federal, state, or local low.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would be only to the appropriate authority or official able to help prevent the threat.

SPECIAL SITUATIONS:

Public Health Risks: We may disclose medical information about you for public health activities. These activities generally include the following:

1. To prevent or control disease, injury, or disability.
2. To report deaths.
3. To report reactions to medications or problems with products.
4. To notify people of recalls of products they may be using.
5. To notify a person who may have been exposed to a disease or may be ast risk for contracting or spreading a disease or condition.
6. To notify the appropriate government authority of we believe you have been the victim of abuse, neglect, or domestic violence.

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law. These activities are necessary for the government to monitor the health care system and for compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court subpoena, discovery request, or other lawful process.

Law Enforcement: We may release medical information if asked to do so by a law enforcement official:

1. In response to a court order, subpoena, warrant, summons, or similar process.
2. To identify a suspect, fugitive, material witness, or victim.
3. In the case of criminal conduct.

Coroners, Medical Examiners and Funeral Directors: WE may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of our practice to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates: If you are an inmate of a correctional institution, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary to provide you with health care or protect your health and safety or the health and safety of others.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes medical and billing records, but does not include psychotherapy notes.

You must submit your request in writing to the Practice Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, and handling.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be made in writing and submitted to the Practice Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that was not created by us or that which we deem accurate and complete.

Right to an Accounting of Disclosures: This right applies to disclosures for purposes other than treatment, payment, or health care operations. To request this list or accounting of disclosures, you must submit your request in writing to the Practice Privacy Officer. Your request must state a time period, which may not include dates before April 14, 2003. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list.

Right to Request Restrictions: You have a right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care purposes. You may also request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the Practice Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice. We will post a dated copy of the current notice in our practice.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Sybil Lawrence, the Privacy Officer, at 404-256-0775. All complaints must be submitted in writing.

You will not be penalized in any way for filing a complaint.

OTHER USES OF MEDICAL RECORDS:

Other uses and disclosures of medical information not covered by this notice will be made only with your written permission, which may be revoked in writing at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we have provided you.

CMED

CENTER FOR MEDICINE, ENDOCRINOLOGY
AND DIABETES, LLC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand my health information is private and confidential. CMED makes continuing efforts to protect the privacy and confidentiality of my personal health information.

I understand that CMED may use and disclose my personal health information to provide health care, to handle billing and payment, and to take care of other health care operations. [There will be no other disclosures of this information unless I specifically permit it. I understand that rarely the law may require the release of information without my permission.]

CMED has a detailed policy called the "Notice of Privacy Practices." It contains information about protecting my privacy. This "Notice of Privacy Practices" may be updated as needed and a copy will be available upon request. I will assist CMED by following office procedures (written request, reasonable time for completion and copying charges where indicated) if I choose to exercise any of my rights described in the "Notice of Privacy Practices." These rights include access, permission for release, record of disclosures, and communication by the available method of my choice.

My signature below indicates that I have read and may request a current copy of CMED's "Notice of Privacy Practices."

_____ _____

Patient or legally authorized signature Date of Birth

_____ _____

Date Relationship to patient if signed by anyone other than the patient

5667 Peachtree Dunwoody Road • Suite 150 • Atlanta, Georgia 30342 • (404) 256-0775

CENTER FOR MEDICINE, ENDOCRINOLOGY AND DIABETES, LLC

FINANCIAL POLICY

There have been numerous changes n health care in the past few years, making it more difficult for us to receive payment for the services that we provide. Therefore, the following is a list of guidelines that are necessary for us to enforce so that we might continue to provide high quality care and make your visit as pleasant as possible.

PLEASE READ ALL INFORMATION AND SIGN WHERE INDICATED.

1. *You are responsible for paying all charges for services rendered to you at CMED*. As a courtesy to you, we will gladly file a claim on your behalf to your insurance carrier, and use all means to assure accurate and timely collection. If payment is not received from your insurance company in a reasonable period of time, we will look to you to pay any outstanding balances, while assisting you in further claims pursuit.

2. We are contractually obligated with your insurance carrier to collect all applicable co-pays from our patients. *Please be prepared to pay this at each visit, or otherwise we will need to reschedule your appointment.*

3. Our office will bill you for any amounts not covered by your insurance plan. Payment is expected upon receipt of that statement. In the event that you do not pay an outstanding balance in a reasonable amount of time, we will pursue collection activities, up to and including legal alternatives. You are responsible for all collection agency and legal fees incurred in our attempt to collect your delinquent account.

4. IF YOUR INSURANCE REQUIRES A REFERRAL: *You* are responsible for making sure your visit have prior authorization by your primary care physician (PCP). *If you arrive for a visit without the appropriate referral, you will either need to pay for your visit charges that day, or reschedule your visit*.

5. SELF PAY PATIENTS: New patients are required to make a $500.00 credit card or cash deposit, prior to their visit. If all the deposit funds are not applied towards that visit's charges, the balance can be left on the account or refunded. *Established patients must pay for all medical services at the time of the visit.*

6. If you are seen for an annual exam, please let our physician know that you would like your visit filed under Preventive Coverage guidelines. Our physicians will make every effort to work with your insurance requirements, however we will code your claim according to the services rendered and the diagnosis, as determined by the physician.

7. If you need one of our physicians to complete administrative forms, there will be a charge for their services. This fee is determined by the amount of the physician's time required, and must be paid prior to completion of the form.

8. We request at least 24 hours notification of cancellations. Chronic cancellations or no-shows will result in your being charged a missed appointment fee.

If you have any questions regarding our financial policy, please call BEFORE the doctor sees you at 404-256-0775.

I acknowledge receipt and understanding of the above Financial Policy for the Center for Medicine, Endocrinology and Diabetes, LLC.

_____ _____

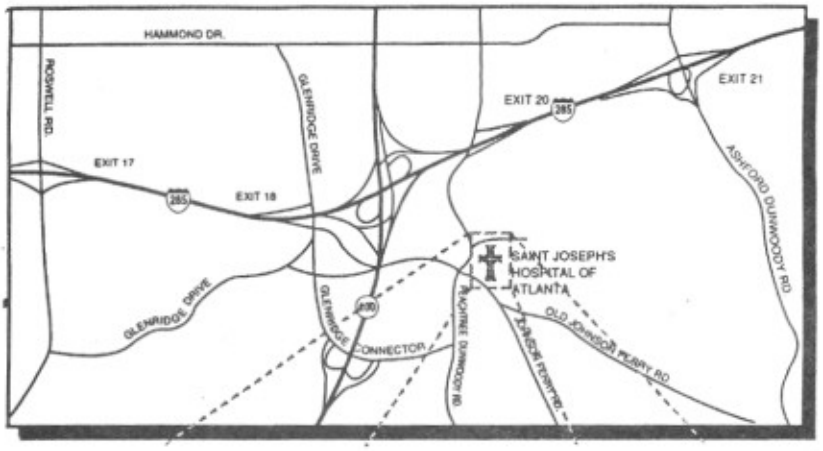
Patient or Guardian Signature Date

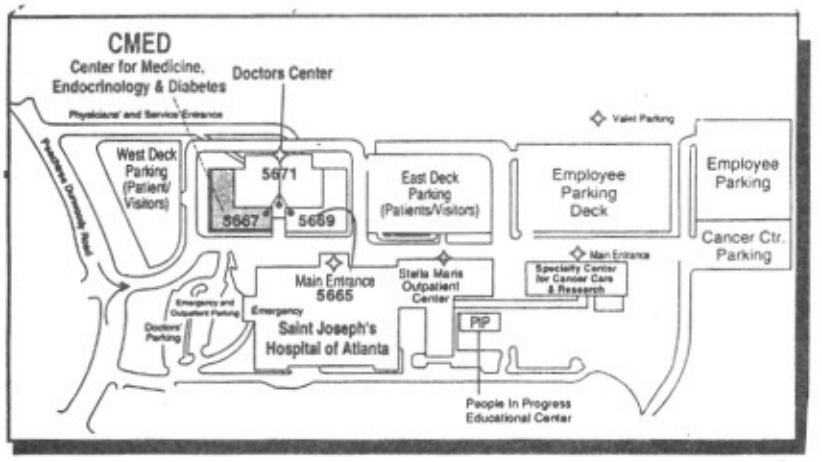
_____

Printed Name of Patient

CMED

Center for Medicine, Endocrinology and Diabetes, LLC





From Downtown

Take I-85 North to GA 400 (exit 87). Take exit 4A (Glenridge Connector) and turn right (Glenridge Rd.). Go to the second light and turn left (Peachtree Dunwoody Rd). Go through the next light (Johnson Ferry Rd.) and immediately enter the far right-hand lane. Turn right into the hospital campus. Bear left to Doctor's Center parking. The Center for Medicine Endocrinology and Diabetes is located directly across from the parking deck.

From Marietta, Smyrna, Chattanooga

Take I-75 South to I-285 East. Take exit 26 (Glenridge Connector). Turn right at the end of the ramp (Glenridge Rd.) Immediately enter the far left-hand lane. At the first light, turn left (Johnson Ferry Rd.) At the third light turn left (Peachtree Dunwoody Rd.), and immediately enter the far right-hand lane. Turn right into the hospital campus. Bear left to Doctor's Center parking. The Center for Medicine Endocrinology and Diabetes is located directly across from the parking deck.

From Roswell, Alpharetta, Cumming, Dahlonega

Take GA 400 South to exit 3 (Glenridge Connector) and turn right (Glenridge Rd.) Got the third light and turn left (Peachtree Dunwoody Rd.) Go through the next light (Johnson Ferry Rd.) and immediately enter the far right-hand lane. Turn right into the hospital campus. Bear left to Doctor's Center parking. The Center for Medicine Endocrinology and Diabetes is located directly across from the parking deck.

From Birmingham and all points west of St. Joseph's Hospital

Take 1-20 East to I-285 North (past I-75) and take exit 26 (Glenridge Connector). Turn right at the end of the ramp (Glenridge Rd.) Immediately enter the far left-hand lane. At the first light, turn left (Johnson Ferry Rd.) At the third light turn left (Peachtree Dunwoody Rd.), and immediately enter the far right-hand lane. Turn right into the hospital campus. Bear left to Doctor's Center parking. The Center for Medicine Endocrinology and Diabetes is located directly across from the parking deck.

From Augusta and all points east of St. Joseph's Hospital

Take I-20 West to I-285 (I-85, I-285 North will become I-285 West). Go to exit 28 (Peachtree Dunwoody Rd.) and turn left. At the third traffic light, just past the MARTA station, turn left in the hospital campus. Bear left to Doctor's Center parking. The Center for Medicine Endocrinology and Diabetes is located directly across from the parking deck.

5667 Peachtree Dunwoody Road • Suite 150 • Atlanta, GA 30342 • (404) 256-0775