



CENTER FOR MEDICINE, ENDOCRINOLOGY
AND DIABETES, LLC

Dear

It is a pleasure to welcome you to our practice of Internal Medicine and Endocrinology, and to 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. Lastly, we request that you complete the enclosed forms and bring them with you to your first appointment. Do not mail them back to us.

We are looking forward to seeing you on _____ .

Please arrive 15 minutes prior to your appointment time in order to complete the check-in process. Make sure you bring your insurance card and referral form from your PCP if required by your insurance company.

Please remember to have your referring physician's office fax your needed information to 404-256-6281. NOT having this information will delay your appointment.

CANCELLATION POLICY:

If you must cancel or reschedule your appointment, you must give a 24-hr notice to our office by 1:00 p.m. the previous day. If your appointment is on a Monday, please call and cancel the previous Friday by 1:00p.m. If you cancel, do not show, or miss your appointment without the required notice we will assess a \$100.00 non refundable cancellation fee. This fee is strictly enforced and will not be covered by your insurance.

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.:

()

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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

REVIEW OF SYSTEMS

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

SYMPTOM

General

Fever
Fatigue
Weight change > 10 lbs.
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
 Excessive hair growth
 Loss of hair
 Acne
 Breast enlargement
 Excessive 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

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	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____



CENTER FOR MEDICINE, ENDOCRINOLOGY
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FINANCIAL POLICY

There have been numerous changes in 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 in order to continue to provide high quality care and make your visit as pleasant as possible. PLEASE READ ALL INFORMATION AND SIGN IN BOTH AREAS INDICATED.

1. We will collect your deductible, co-pay, uncovered services or percent responsibility at the time of your visit.
2. Please be thorough with your insurance information if you expect us to file your claims for you. Always bring your current insurance card and any authorization needed that you may have. You will be responsible for any unpaid balances due to lack of information.
3. We will file your insurance claims for you. It is your responsibility to make sure we receive prompt payment from them (within 30-45 days is usual). It is useful to maintain frequent contact with your insurance carrier to make sure they are paying, as they should.
4. Your insurance will send you an explanation of benefits that explains what they have paid to our office. This is a record that you must keep on file. If you do not agree with their payment, please contact the insurance company.
5. If your insurance denies payment on your account, you will be asked to pay by check, cash, MasterCard, or Visa. If you do not pay in a timely fashion, your account may be put into collections.
6. TO ALL MEDICARE PATIENTS: We will continue to participate as Medicare providers. We will bill Medicare as well as secondary insurance, but if payment is not received from your secondary insurance in 45 days, you will be notified and must pay our office the balance due. You must then contact your secondary insurance to pay you for the balance you paid our office.
7. HMO or PPO PATIENTS REQUIRING A REFERRAL: You are responsible for making sure your visits have prior authorization by your primary care physician (PCP). If you do not see the doctor for six or more months. You must contact your PCP and be

referred to our office again. This is not our policy but the policy of the insurance companies that you are contracted with. Ultimately, it is the patient's responsibility to make sure that we have received authorization from your insurance company. If your insurance denies your claim due to lack of authorization, the office visit will be billed to the patient.

8. SELF PAY PATIENTS: This category includes those people with no insurance and those patients who have an indemnity plan and wish to file their own insurance. Payment for our medical services is expected before the service is rendered. We accept cash, check, money orders, MasterCard, and Visa. If you will not be able to pay for services in full, you must contact our office to make payment arrangements before coming to see the doctor. If you have no prior agreement with our office payment in full will be expected.

9. If your insurance is out of state (except for PPO insurance) you must pay for your visit at the time of service. Most of the out of state insurance companies pay the patient and will not pay us directly (even if they tell you they will). Payment will be collected up front in full and we will provide you with all appropriate information to file them yourself.

10. You must let the doctor know if your insurance company will not pay for routine or well visit exams. Our physicians will make every effort to work with your insurance requirements, however we will code your claim according to the diagnosis as determined by the physician.

FOR YOUR INFORMATION

Our practice's policy is to file claims to insurance companies in a timely fashion.

Remember you and /or your employer pay the monthly insurance premiums. Your insurance company is accountable to you not us. Please do not hesitate to contact them if you disagree with their payment or to find out the status of your claim.

If you have any questions regarding our financial policy, please call BEFORE the doctor sees you. (770 256-0775)

Patient or Guardian Signature

Date

PLEASE NOTE:

Our participation with your insurance company does not guarantee their payment of your bill.

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.

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 law.

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 at risk for contracting or spreading a disease or condition.
6. To notify the appropriate government authority if 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.



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

REFERRAL PROCESS

- ✓ ALL HMO AND POS PATIENTS **MUST** HAVE A REFERRAL AT TIME OF SERVICE (Before seeing the doctor).

- ✓ PATIENTS WITHOUT A VALID REFERRAL HAVE THE OPTION TO SIGN A WAIVER ACCEPTING RESPONSIBILITY FOR PAYMENT.

- ✓ OBTAINING A REFERRAL IS PATIENT RESPONSIBILITY FOR:
DR. BEASLEY, III
DR. SILVERMAN
DIAGNOSTIC PROCEDURES (Some need different referral #)
REFERRAL TO ANOTHER PHYSICIAN

- ✓ ALL REFERRALS HAVE VISIT LIMITATIONS AND EXPIRATION DATES. IT IS PATIENT RESPONSIBILITY TO KEEP REFERRALS VALID.

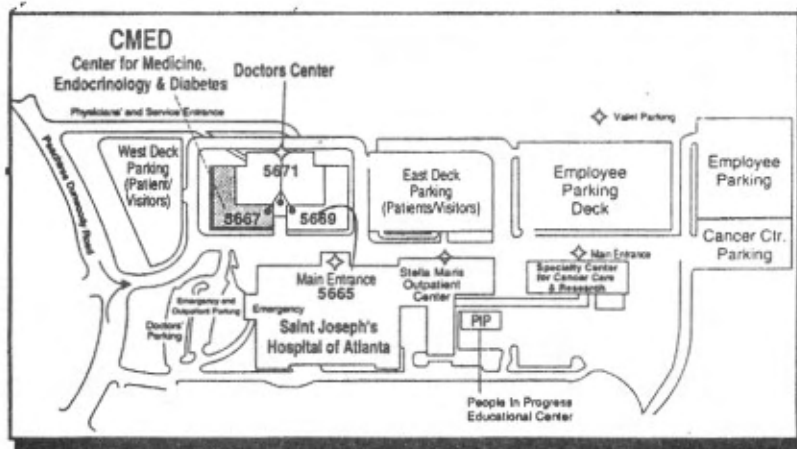
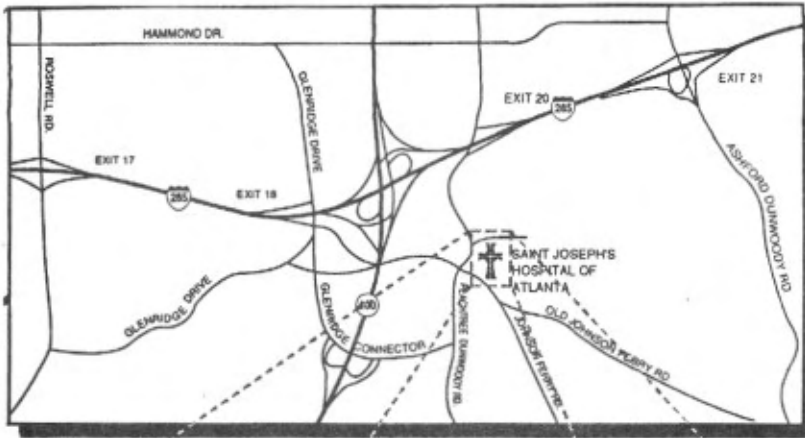
- ✓ NOT FOLLOWING THESE PROCEDURES MAY DELAY YOUR VISIT AND IN SOME INSTANCE YOU MAY BE ASKED TO RESCHEDULE.

THANK YOU IN ADVANCE FOR YOUR COOPERATION.

CMED



CENTER FOR MEDICINE, ENDOCRINOLOGY AND DIABETES, LLC



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 I-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.

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.