CMED

CENTER FOR MEDICINE, LLC.

Dear Patient,

It is a pleasure to welcome you to our practice of Internal Medicine. 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.

Please complete the enclosed forms and bring them with you to your first appointment.

DO NOT MAIL THE FORMS BACK TO OUR OFFICE.

Please arrive 15 minutes prior to your appointment time in order to complete the check-in process. Make sure to bring your insurance card(s) and photo ID with you to your first appointment.

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

AM APPOINTMENTS – FAST FROM MIDNIGHT (DAY BEFORE)
PM APPOINTMENTS – FAST FOR 4 HOURS (PRIOR TO APPOINTMENT TIME)

During the fasting period, you may have water, black coffee, and unsweetened tea.

IN ADDITION, WE REQUEST THAT YOU DO NOT WEAR ANY LOTION OR STRONG PERFUME/COLOGNE ON DAY OF YOUR APPOINTMENT.

PLEASE FEEL FREE TO CALL WITH ANY QUESTIONS.

Shantell 404-256-0775

5667 Peachtree Dunwoody Road, Suite 150 Atlanta, GA 30342

Center for Medicine, Endocrinology & Diabetes, LLC.

REGISTRATION FORM

(Please Print)

Date:

PCP:

PATIENT INFORMATION					
Last Name	First	M.I.	D.O.B:	Marital Status	Single / Mar / Div / Sep / Wid
Street Address			Apartment/Unit #		
City	State		Zip Code		
Home phone	Cell phone	E-mail Address			
Social Security#	Is this your legal name?		If not, what is your legal name?		
Employer			Employer phone		
Race	American Indian/Alaskan Native ☐	Asian ☐	Black/African American ☐	Native Hawaiian/Other Pacific Islander ☐	White ☐ Other ☐
Ethnicity	Hispanic/Latino ☐	Non-Hispanic/Latino ☐			
Preferred Language	English ☐	Spanish ☐	Other ☐ If other, which language do you prefer? _____		
Referring Physician					

INSURANCE INFORMATION			
(Please give your insurance card(s) 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. #	Date of Birth	
Policy #	Group #	Co-payment $	
Relationship to subscriber Self ☐ Spouse ☐ Child ☐ Other ☐			
Name of secondary insurance (if applicable)	Subscriber's Name	Date of Birth	
Policy #	Group #		
Address			
Relationship to subscriber Self ☐ Spouse ☐ Child ☐ Other ☐			

IN CASE OF EMERGENCY		
Name of local friend or relative (not living at the same address)	Relationship to patient	Primary Phone #

DISCLAIMER AND SIGNATURE	
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 Center for Medicine, Endocrinology & Diabetes, LLC. to release any information required to process my claims.	
Signature	Date

CENTER FOR MEDICINE, ENDOCRINOLOGY AND DIABETES, LLC
Treatment and Education for a Lifetime of Health.

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 # 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	Age at death	Cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers/Sisters	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

_____
_____
_____

SYSTEMS REVIEW

Please circle any of the following symptoms which you are currently experiencing.

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)
Hay fever/allergies
Dizziness/vertigo
Snoring

Cardiovascular

Palpitations
High blood pressure
Chest pain
Heart disease
Heart murmur
Mitral valve prolapsed
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 testicle
Large prostate
Prostatitis
Prostate cancer
Impotence
Cannot have erections
Lack of sexual desire
Cannot have orgasms

SYMPTOM

Skin

Color/texture changes
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

Reproductive, male (cont'd)

Sexually transmitted diseases
Hernia
Last PSA____(date) and level____

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/enlarged 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? (Include a total of successful and unsuccessful)_____
How many pregnancies went to term?_____
Weight(s) of newborns?_____
How many pregnancies were premature?_____
How many miscarriages/abortions have you had?_____
Any complications with any pregnancy?_____
Did you have a hysterectomy? (include date)_____
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

CENTER FOR MEDICINE, ENDOCRINOLOGY AND DIABETES, LLC
Treatment and Education for a Lifetime of Health

CONSENT FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE:

_____

TO RELEASE INFORMATION FROM THE MEDICAL RECORD OF:

_____

Patient's Full Name

_____

Patient's Date of Birth

To: **The Center for Medicine, Endocrinology & Diabetes**
5667 Peachtree Dunwoody Road, Suite 150
Atlanta, Georgia 30342
Phone: 404-250-6722
Fax: 404-250-6702

Attn: _____
Physician's Name

This is information is to be released for the purpose of:

_____

_____

_____ _____

Date **Patient's Signature/Responsible Party**

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

CENTER FOR MEDICINE, ENDOCRINOLOGY
AND DIABETES, LLC
Treatment and Education for a Lifetime of Health.

ANNUAL ROUTINE PHYSICAL EXAMINATION

A majority of insurance companies will pay 100% for a routine physical examination once per year. Depending on your insurance policy; blood work, chest x-ray, EKG, spirometry may not be covered 100% and may be subject to your deductible and/or co-insurance.

There has been frequent confusion regarding the difference between a Preventative Exam and a Regular Office Visit. If an ongoing medical problem is in anyway unstable or if a new problem is found, your insurance carrier may define this visit as a "regular" office visit and not part of your Preventative coverage.

I UNDERSTAND THAT MY INSURANCE /MEDICARE MAY NOT PAY FOR THESE SERVICES AND WILL ACCEPT RESPONSIBILITY FOR PAYMENT.

Patient Signature_____

Print Name_____

Date_____

CENTER FOR MEDICINE, ENDOCRINOLOGY AND DIABETES, LLC
Treatment and Education for a Lifetime of Health.

Appointment Policy

Due to the number of patients who do not notify us when they are unable to keep their appointment, we have adopted the following policies:

APPOINTMENTS:

If you are unable to keep your appointment, you must give us at least 24 hours' notice. Not doing so will result in a **$35.00 missed appointment fee**. If you fail to notify us on a continuous basis, you may be discharged from the practice.

LATE PATIENTS:

If you arrive more than 20 minutes past your scheduled appointment time, we may ask that you reschedule. If our schedule allows, we will reschedule you within the same day. If not, we will reschedule you for the earliest available opening.

I have read and understand the above policies and agree to abide by these policies. I, hereby, acknowledge that I am responsible for keeping my scheduled appointments and have been informed of the policy of Center for Medicine, LLC. This charge, if incurred, cannot be billed to my insurance company.

_____ _____

Patient name (please print) Date

_____

Patient (or Legal Guardian) Signature

Center for Medicine, LLC

Form Completion Policy

If you need a form filled out by your physician, below you will find the cost associated with each type of form.

Family Medical Leave Act (FMLA) Paperwork:

$25.00 for a single page up to $50.00 maximum

Disability Paperwork:

$25.00 for employer information requests, physician statements or disability insurance requests.

Attorney's Paperwork:

$50.00 minimum for letter or reports sent on your behalf

Itemized Statements:

$10.00 for every statement after first request (1st statement at no charge)

Miscellaneous Paperwork (supplies, etc):

$25.00 minimum per page (at physician's discretion)

***Patient must be current on their account before any forms will be completed.

_____ _____

Patient Signature Date

PATIENT WAIVER FOR COVERED AND NON-COVERED SERVICES

Patient's Name: _____ Date: _____

Physician: _____

Due to the healthcare changes your insurance may not pay for all of your healthcare costs. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services.

Your physician believes that certain procedures and or test performed are an important part of your medical care and recommends that you receive these services as part of your current treatment plan, although they may be covered but not at %100 by your health insurance.

However, in cases that the services rendered are not considered to be a medically necessary benefit under your health insurance, should you choose to receive these services; you will be personally responsible for the payment of such services.

I acknowledge that I have been informed in advance before receiving services, that some services are not covered by my health insurance plan. I have chosen to receive these services and understand that I will be financially responsible for the charges indicated above.

Print Patient Name _____

Patient Signature _____

Name of Parent or Legal Guardian (if applicable)_____

Signature of Parent or Legal Guardian (if applicable)_____

This form must be signed by the patient or legal guardian PRIOR to receiving any services or items and *must be maintained in the patient's medical record.*

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

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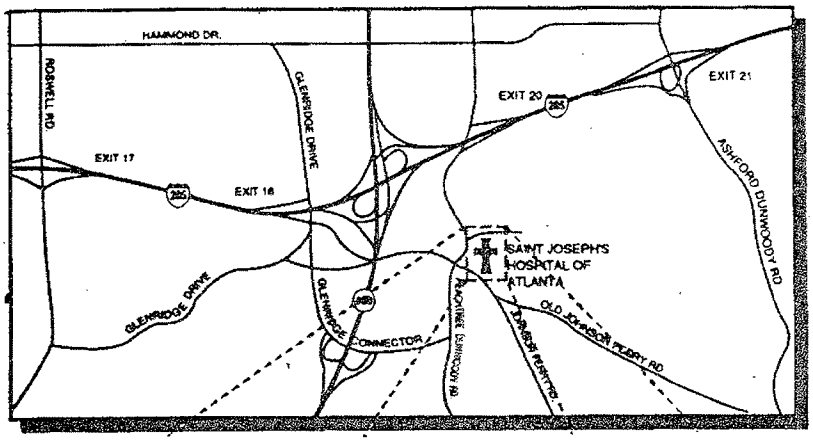

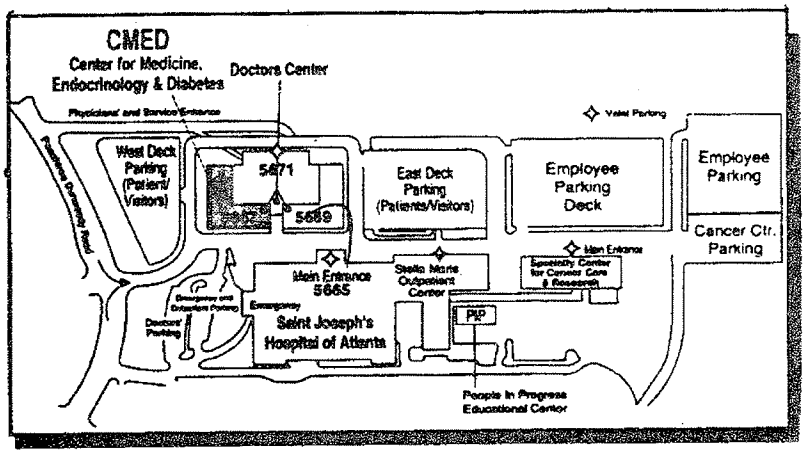

CMED

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.

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