North Georgia Endocrinology

Date: _____ Referring Physician (if applicable): _____

PATIENT REGISTRATION INFORMATION

PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____

DOB: _____ Marital Status: ☐ Married ☐ Single ☐ Partner ☐ Divorced ☐ Widowed

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ Cell/Alternate: (_____) _____

Email Address: _____

If patient is over 18, please select one: ☐ Full-time ☐ Part-time ☐ Not employed ☐ Student ☐ Retired

Please write in "N/A", if not applicable to you or an "X" if you do not wish to disclose

Race: _____ Ethnicity: _____ Language (primary): _____

Sex assigned at birth: _____ Gender Identity: _____ Pronouns: _____

PHARMACY: (If express script or other mail order pharmacy, please indicate):

Pharmacy Name: _____

Address: _____

Phone: _____

IN CASE OF EMERGENCY CONTACT:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

North Georgia Endocrinology

MEDICAL ILLNESSES:

_____ _____

_____ _____

_____ _____

SURGERIES (Please included any scheduled surgeries as well)**:**

_____ _____

_____ _____

_____ _____

MEDICATIONS (including non-prescription, supplements, vitamins, etc.):

RX	Dosage	Times Daily

DRUG ALLERGIES:

_____ _____

_____ _____

_____ _____

FAMILY MEDICAL HISTORY:

RELATIVE	ILLNESSES
Mother	
Father	
Sister(s)	
Brother(s)	
Grandmother	
Grandfather	

HABITS:	YES	NO
Tobacco:	_____	_____
Alcohol:	_____	_____
Recreational Drugs:	_____	_____

North Georgia Endocrinology

3180 North Point Parkway, Suite 302
Alpharetta, Georgia 30005
Phone:(678) 224-8686 * Fax: (770) 224-8779

1. PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorized you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.
I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

2. PATIENT AUTHORIZATION FORM:

This authorization sets forth your right to use or disclose my protected health information as specified below for the purposes and parties as designated below.

DESCRIPTION OF SPECIFIC INFORMATION AUTHORIZED:
Any information needed to process insurance claim forms.

DESCRIPTION OF THE SPECIFIC PURPOSES FOR USE AND DISCLOSURE:
Billing purposes

PARTIES REQUESTING INFORMATION AND AUTHORIZED TO USE AND DISCLOSE THE INFORMATION:
Authorized representative of my insurance carrier

PARTIES TO WHOM INFORMATION MAY BE DISCLOSED:
Authorized representative of my insurance carrier

I reserve the right to:

- Revoke this authorization in writing by submitting it to the attention of your Privacy Officer
- Inspect or copy the protected health information to be used or disclosed
- Refuse to sign this authorization knowing that you will condition treatment or payment on my providing this authorization (except for research related treatment)

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.
Under certain circumstances we may receive compensation from a third party requesting your medical records.

Print Patient Name: _____

Signature: _____

North Georgia Endocrinology

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Alpharetta, Georgia 30005

Phone: (678) 224-8686 * Fax: (770) 224-8779

FINANCIAL POLICY

If covered by health insurance, please present a current insurance identification card. Please notify our office if your coverage should change. It is the responsibility of the patient to obtain a referral if needed, All co-payments will be collected at the time of service before your visit with the provider. **Deductibles, co-insurance, and any unpaid balance will also be collected at the time of service.** As a courtesy to you, we will file your claims for you. For your convenience we accept cash, VISA, Mastercard, Amex and Discover. **We do not accept checks.** If your insurance company does not pay your claim, you will be responsible for the balance. If you are a private pay patient, payment in full is expected at the time of service unless prior arrangements have been made. Statements will be sent every thirty (30) days. Unpaid accounts will be sent to an outside collections agency at ninety (90) days. You will also be responsible for a collection fee of 25% of the past due amount.

Charges for copying medical records are based on the charges set forth by the Georgia Office of Planning and Budget pursuant to O.C.GA. 31-33-3. In order to comply with HIPAA regulations, a signed, written request for medical records must be received along with the payment before records can be released.

If you are unable to keep your appointment or need to change it, please call our office at 678-224-8686 at least 24 business hours prior to the scheduled appointment to avoid being charged a **$50.00 rescheduling fee**.

There is a $50.00 fee for follow-up patient "no shows." Please remember it is the patient's responsibility to keep up with scheduled appointments, but as a courtesy we do our best to provide a reminder call two days prior to the scheduled appointment as well as reminder text messages and emails closer to the appointment date. Two consecutive “no shows” in a row will result in dismissal as a patient from our practice and the inability to schedule new appointments.

* **All outstanding balances MUST BE CLEARED prior to scheduling or being seen at a follow up appointment.** Prescription refills will also be halted, unless deemed urgent for a one time refill, until all balances are cleared. Accounts outstanding for 3 months will automatically be sent to collections.

I have read and understand the above financial policy:

Signature: _____ Date: _____

North Georgia Endocrinology

NEW PATIENT AGREEMENT

Our providers practice traditional Endocrinology. While we devote tremendous care and time to each patient while discussing health concerns, we are unable to manage additional care outside of the scope of endocrinology.

We are a specialty office and cannot function as your primary care physician (PCP). We do advise all of our patients have a primary care physician who can manage their health through a wider scope of care alongside their network of specialists.

Patient endocrine system evaluation is done at our provider's discretion and not solely per patient request. We value evidence based management and want to have a mutually respectful clinical relationship.

For patients with hypothyroidism or hyperthyroidism:

Our practice may consider desiccated thyroid medication in some cases and base medication dosage on TSH levels. We do not check reverse T3 levels unless clinically indicated.

For our patients with Diabetes:

While we understand managing a chronic medical disease is difficult, we do expect our patients to be equally interested in optimal management of their diabetes. We require:

1) Compliance with medication regimen as recommended by Dr. Ahmad or Carolyn Lawson
2) Sugar monitoring
3) Maintaining up to date lab-work and follow ups

Patients with an A1C over 10% are required to follow up every 2-4 weeks until sugars are in a controlled range. Patients with an A1C in the range of 8-10% must follow up every 4-6 weeks until sugars are under control. Except under extenuating circumstances, if labs and follow up appointments are more than a month out of the recommended schedule, you may be at risk of being dismissed from our practice.

* Diabetic patients are required to follow up **EVERY 3 MONTHS** or they will risk dismissal from our practice. A 6 month follow up period may be approved based on provider discretion.

Please sign below to acknowledge the new patient agreement:

Signature: _____ Date: _____

North Georgia Endocrinology

CLINIC POLICIES

For New Patients:

- We only allow a **ONE TIME** reschedule if requested over 24 business hours from the appointment time.
- New patient appointments that are cancelled less than 24 business hours from the appointment time or are a "no show" **will only be rescheduled once and will be subject to a $50 rescheduling fee.**
- Refills may take 48-72 business hours. Please plan accordingly. If you are overdue for labs and follow up, a one time ONE month refill will be sent at the providers discretion. Please make sure labs and follow up appointments are completed prior to the completion of the short term supply.
- **Please note copays, deductibles, and coinsurances are due at the time of service.**

For Follow-up patients:

- **If there is a "no show" or less than 24 hour business hour cancellation, there is a $50 fee to reschedule the appointment.**
- **Our providers are unable to call patients or respond to excessive and elaborate portal messages.** Discussions outside of quick questions which can be answered by our medical staff will require a scheduled appointment to address all concerns at once.
- **Please use the patient portal** (21702.portal.athenahealth.com) **for communication**. Do not use the admin email. **Please limit calls to the office as we are with patients most of the day and can better respond to a limited number of short portal messages.**
- **Please note copays, deductibles, coinsurances, and all outstanding balances are due at the time of service. All outstanding balances or accounts in collections must be paid off in full before scheduling new appointments.**
- Please note our staff is working hard and covering multiple tasks at any given time. PLEASE DO NOT CALL REPEATEDLY. We are a busy clinic. ANY TASK CAN TAKE UP TO 3 BUSINESS DAYS TO COMPLETE. IF IT IS URGENT, YOU MAY NEED TO SCHEDULE A SAME DAY APPOINTMENT IF AVAILABLE.
- Please note that rude behavior of any kind is not acceptable and is grounds for dismissal from the practice. We value our employees. We value our patients. We expect mutually respectful communication. NO EXCEPTIONS.

Please sign below to acknowledge the clinic policies and procedures:

Signature: _____ Date: _____

Authorization To Release

North Georgia Endocrinology

Name:_____ **Date of Birth:** _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described below are not health plans, health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information policy laws.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To inspect or copy the protected health information to be used or disclosed.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To refuse to sign the authorization.
- To a statement that covered entity may receive remuneration from use or disclosure of requested information.
- To a copy of this form.

I understand that I may revoke this authorization at any time by giving written notice. However, I understand that I may not revoke this authorization for actions taken before receipt of my written notice to revoke this authorization or if the covered entity had taken action in reliance thereon. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and if I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

I (the patient) am requesting that you (North Georgia Endocrinology) may release the following information regarding my health information to:

(Appointment Information, Medical Records, or Health Information)

- ***Please list the name of Person(s) to whom we may release information*:**

  Name_____ **(Relationship to patient)** _____
  Name_____ **(Relationship to patient)** _____
  Name_____ **(Relationship to patient)** _____

- ***Please identify the information that may be released to this person*:**

  _____**Appointment Information** _____**Treatment Information** _____**Health Information** _____**Account Information** _____**All of the Above**

- ***May we leave a message/contact you regarding***

	Home Phone	***Work Phone***	***Cell Phone***
Appointments:	**Yes/No**	**Yes/No**	**Yes/No**
Lab Results	**Yes/No**	**Yes/No**	**Yes/No**
Office Information	**Yes/No**	**Yes/No**	**Yes/No**

Signing this authorization is not a condition of treatment. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, of (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

I have had the chance to read and think about the consent of this authorization form and I agree with all statements made in this authorization. I understand that by signing this form, I am confirming my authorization for use and/ or disclosure of the protected health information described in this form with the people and/or organization named in this form.

X_____ _____

Signature of Patient or Legal Representative — Date

North Georgia Endocrinology

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name, if applicable: _____

Street Address: _____ City/State/Zip: _____

Home/Cell Number: _____ Work Phone: _____

1. **RELEASE TO/FROM:**
   I authorize representatives from the following facility / facilities to disclose the above-named individual's health information as directed below

   Practice/Facility Name: _____

   Practice/Facility Phone: _____

   Practice/Facility Fax: _____

2. **FAX REQUESTED INFORMATION TO/FROM:**

   North Georgia Endocrinology

   Attn: Medical Records (MUST INCLUDE Patient's Full Name and DOB)

   Fax: 678-224-8879 Phone: 678-224-8686

3. **PURPOSE OF DISCLOSURE:**
   - ☐ Continuity of Care
   - ☐ Insurance Disability
   - ☐ Other:

4. **EXPIRATION OF AUTHORIZATION:**
   Unless I request in writing otherwise, this authorization will expire on_____. If I do not specify an expiration date or (insert date or event) event, this authorization will expire ninety (90) days from the date on which it was signed.

5. **DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:**

   ☐ Complete medical record / health information (please specify dates of service):

   _____

   ☐ Partial medical record (please specify records below):

   _____

6. **RIGHT TO REVOKE AUTHORIZATION:** I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present written revocation to the Medical Records Department of North Georgia Endocrinology or facilities checked above. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

7. **FEES:**
   I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees. The fee schedule may be viewed at dch.georgia.gov/medical-records-retrieval-rates.

8. **REFUSAL TO AUTHORIZE USE AND/OR DISCLOSURE:**
   I understand that authorizing the use or disclosure of the information above is voluntary. I need not sign this form to ensure healthcare treatment.

9. **RE-DISCLOSURE:**
   I understand that if my health information is disclosed to a party other than a healthcare provider, health plan, or healthcare clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

10. **RELEASE AND WAIVER:**
    If the health information that I have requested North Georgia Endocrinology PC to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), Immunodeficiency Syndrome Related Complex (ARC), human immunodeficiency virus (HIV), venereal disease, tuberculosis, or hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above.
    I also release North Georgia Endocrinology and their officers, trustees, agents, and employees from any and all liabilities, damages, and claims which might arise from the release of the health information authorized by me above.

Printed Patient Name: _____ DOB: _____

Signature of Patient (or Patient's Legal Representative) _____

Description of Authority to Act for Patient _____ Date: _____