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

CMED

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

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____

Telehealth Consent Form

Patient Name: ______________________________ DOB: ______________

Provider Name: ______________________________

I hereby consent to receive healthcare services through telemedicine or telehealth platforms provided by Center for Medicine, LLC. I understand telehealth services may involve video conferencing, audio, and/or other electronic communication to connect me with my healthcare provider.

I understand that regular office visit copayments and coinsurance will apply for telehealth. I understand that copayments will need to be collected prior to the telehealth appointment.

I understand that my healthcare provider will make every effort to ensure the security and privacy of my personal and medical information. However, I acknowledge that there are risks associated with electronic communication and that my information could be intercepted or disclosed without my consent.

I understand that my healthcare provider will document my telehealth visit and that my medical records will be maintained in accordance with state and federal regulations.

By signing below, I acknowledge that I have read and understand the information provided in this Telehealth Consent Form and consent to receive healthcare services through telehealth platforms.

Patient Signature: ______________________________

Date: ________________

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.*

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.

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.

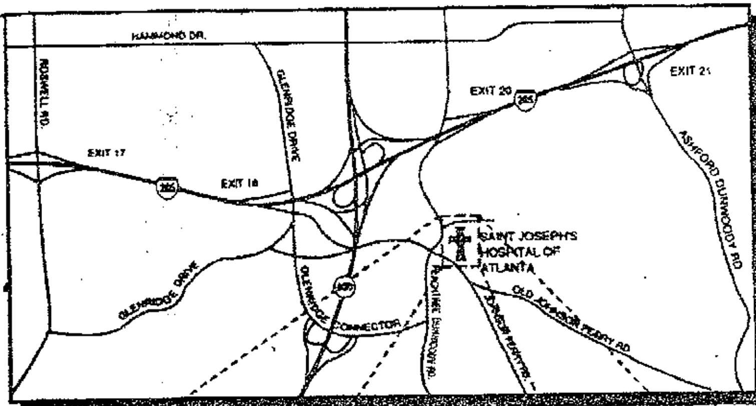
My signature below indicates that I have read and may request a current copy of CMED's "Notice of Privacy Practices."

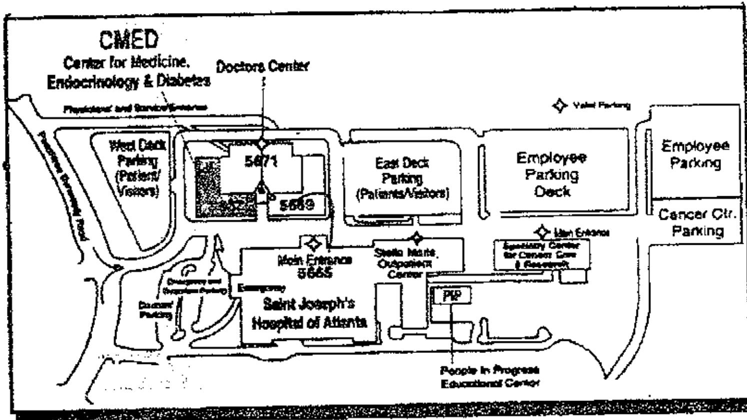
______________________________ ________________
Patient or legally authorized signature — Date of Birth

________________ ______________________________
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





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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