



**Atlanta Diabetes Associates
Patient Registration Form**

Date: _____
Chart #: _____

Which Doctor are you seeing today: _____

Patient Name: _____
First Middle Last

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Date of Birth: _____

Cell Phone: _____ Mobile Carrier: _____ Social Security: _____

Marital Status: _____ Sex: M or F Email Address: _____

What Doctor referred you here? (Doctors first and last name) _____

Doctor's Address: _____

Doctor's Phone Number: _____ Fax Number: _____

What Doctor has been treating you for your condition? _____

Primary Insurance: _____ Effective Date: _____

Policy Holder's Name: _____ DOB _____ SS# _____

Relationship to Patient: _____ Policy # _____ Group #: _____

Group Name: _____ Copay: _____

Secondary Insurance: _____ Effective Date: _____

Policy Holder's Name: _____ DOB _____ SS# _____

Relationship to Patient: _____ Policy # _____ Group #: _____

Group Name: _____ Copay: _____

Emergency Contact Person: _____ Relationship to Patient: _____

Emergency Phone Number: _____

PLEASE PROVIDE THE FRONT DESK WITH YOUR INSURANCE CARD (S)



CONSENT & FINANCIAL AGREEMENT

Medical consent for Treatment: The undersigned hereby grants authorization for treatment and procedures that are deemed necessary by his/her physician. The undersigned is aware that the practice of medicine is not an exact science, and the undersigned acknowledges that no guarantees have been made as to the result of treatment rendered.

Release of Information: The undersigned hereby authorizes Atlanta Diabetes Associates and/or Diabetes Supply and Training Center to release to third party payers pre-certification or medical records information regarding his/her examination or treatment for purposes of obtaining insurance compensation.

Financial Agreement: For and in consideration of the goods and services rendered and to be rendered by or through Atlanta Diabetes Associates and/or Diabetes Supply and Training Center, the undersigned agrees to make payment in full upon receipt of final billing.

Warranty Disclaimer: Atlanta Diabetes Associates and/or Diabetes Supply and Training Center make no representation or warranty of any kind, expressed or implied, with respect to any goods sold hereunder or otherwise provided in connection with any services rendered, whether to merchantability, fitness for a particular purpose, or any other matter.

THE UNDERSIGNED CERTIFIES THAT HE/SHE READ THE FOREGOING, THAT ANY QUESTIONS HAVE BEEN FULLY EXPLAINED, AND THAT HE/SHE UNDERSTANDS ITS CONTENTS. THE UNDERSIGNED HEREBY AGREES TO ALL TERMS SET FORTH IN THIS DOCUMENT.

Signature of Patient or Legal Guardian

Date

Patient's name (Print)

Date



Our Financial Policy

Atlanta Diabetes Associates accepts most major insurance payers. We do not accept Medicaid or Medicare HMO products as a form of payment.

We accept all major credit cards, cash, or check. For checks that are returned not payable there will be a \$75 returned check fee and checks will not be accepted on future visits.

We do not accept post dated checks.

Laboratory Services

Many insurance plans now require you to go to or send your lab specimens to specific laboratories. Please let us know if this is the case. Atlanta Diabetes Associates does have a lab on site and some tests may be performed here while other tests must be referred to an outside laboratory.

Insurance information

It is your responsibility to provide accurate and updated insurance information at each visit. You will be responsible for any balances that your insurance carrier denies as a result of inaccurate information. Please check with our receptionist at each visit to verify if we have the most up to date insurance information and card on file.

It is your responsibility to check with your insurance plan to advise you on your coverage. Most plans are specific to your employer group and we do not know what a covered benefit is under your plan. Your employer benefit advisor at your place of employment will be able to answer your questions regarding coverage and benefits.

It is your responsibility to ensure that our physicians are covered under your health plan. If a referral or authorization is required, you must obtain this from your primary physician or health plan prior to your visit otherwise you will be responsible for all charges.

You are ultimately responsible for payment of charges for services that you receive from our office. If your claim is denied or payment is not made within 30 days from the date of service, you must contact your insurance plan for an explanation and pay us any amounts by your health plan.

Payment of Charges

You are ultimately responsible for payment of charges for services that you receive from our office. Any unpaid balances must be paid in full prior to any additional visits unless arrangements have been made with our financial counselor.

My signature below indicates that I have read and understand this Financial Policy and accept these terms. My acceptance covers my visit today and all future visits.

Signature of Patient or Legal Guardian

Date

Patient's name (Print)

Date



Our Financial Policy

Fees (These are NOT covered by Insurance)

Return Check Fee **\$75**

Copies of Medical Records ***\$variable**

Medical records requests must be received at least 5 business days prior to the date needed. Fees for medical records are set in accordance with allowable amounts defined by the State of Georgia. Fees must be received prior to record delivery. No more than 5 pages will be faxed. Medical Records will not be copied without a patient authorization form, unless a subpoena has been received.

Telephone Consult (During office hours appointment) **\$50 per call**

This is not covered by insurance and is due prior to consult. A credit card may be used to pay for this service.

Telephone Urgent Consult (After hours) **\$75 per call**

When you require advise, a prescription or refill, or for routine problems that require a history, diagnosis, and treatment after hours.

Administrative Services Fee

Form Completion **\$10 per form**

(disability, handicap parking, workers compensation, medical leave, insurance authorization for brand or non formulary drugs, medical releases, letters for employers, school, health clubs, etc.)

*Optional Administrative Fee Plan **\$25 per year**
If you choose this plan, you will be assessed \$25.00.

_____ **I choose to pay the Annual Administrative Fee of \$25 per year**
Patient Initials

_____ **I understand that by not choosing the annual Administrative Fee,**
Patient Initials **I will be charged \$10 per form for my physician to complete.**



Financial Policy

Questions & Answers

What is a Telephone Consult during office hours?

Many times it is too difficult for a patient to come to Atlanta for a full office visit when all they need is to ask the provider simple questions about their medical condition. These consults are scheduled for 15 minutes of telephone time with the provider. You should ask your provider if you are a candidate for this type of service for your next appointment.

What type of forms completion will require payment?

Forms that require a medical professional to complete such as those required for determination of disability coverage; for determination or continuance of worker's compensation coverage or; leave of medical absence as well as other medical forms requiring a physician attestation. In addition, some insurance payers require specialty/non formulary medications to be 'pre-authorized' before filling a prescription. Your provider may need to send a written explanation of why this medication is medically necessary for you to take. Medical releases for employees, school, health clubs, camps and others also require a physician to attest that you are under his care.

Why does ADA have two options to pay for completion of forms, called an Administrative Fee?

Most patients may have no forms to be filled out or only one form per year and the option to pay per form would be the best choice. You can always choose the annual option at a later time. However, if you are on a disability and/or require multiple medical releases; are applying for or need a continuance for your workers compensation; require specialty medications that your insurance requires authorization for, then you should consider choosing the option to pay \$25 per year. These forms require the physician to completely review your medical chart to complete these forms, this process can take up to or over 1 hour to complete.

If I call during business hours to speak with my provider or to request a prescription refill will I be charged?

No. If you call during business hours and speak to or leave a message to have one or more prescriptions filled you will not be charged for this service. If you call AFTER business hours and speak to our answering service to have a doctor called or paged to call you, then you will incur a charge for this consultation. You may leave messages with our answering service after regular business hours for issues that can wait until the next business day, go to your nearest urgent care center if necessary, or to the closest emergency room.



PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Atlanta Diabetes Associates to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Atlanta Diabetes Associates' Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Atlanta Diabetes Associates reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Atlanta Diabetes Privacy Office at 77 Collier Rd, Suite 2080, Atlanta, GA 30309.

With this consent, Atlanta Diabetes Associated may call my home, send e-mail or mail to my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO. These items include but are not limited to appointment reminders, insurance items, correspondence from the physicians, any calls pertaining to clinical care, including laboratory results, and patients statements.

I have the option to request that Atlanta Diabetes Associates restrict how it uses discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restricted, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Atlanta Diabetes Associates' use and disclosure of my PHI to carry out TPO with those organization and health providers necessary for my medical care.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Atlanta Diabetes Associates may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date

Patient's name (Print)

Date