EAGLE'S LANDING DIABETES & ENDOCRINOLOGY
550 Eagles Landing Parkway, Suite 110 Stockbridge, GA 30281 PHONE: (770) 389-9494 **FAX: (770) 357-2511**

2025 NEW PATIENT CHECK LIST

- Insurance Card & Identification
- New Patient Packet (Please complete your packet & Arrive 5 min. prior to your scheduled appt.)
- Bring In Medication Bottles or List of all medications & vitamins
- Diabetic patients: bring your Blood Glucose Monitor and/or Pump.
- Face Mask Optional
- No additional guest, children, or family allowed in the building. **(You may bring 1 person to the office if you need physical or mental assistance.)**
- **Failure to comply to our office policies. Will result with the immediate cancellation of your appt.** *We advise that you request a copy of our office policies for future reference.

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Welcome to Eagle's Landing Diabetes & Endocrinology! We are happy that you have chosen us to be your endocrinologist. Here is a checklist of things to bring to your first appointment:

- If you have diabetes, bring your diabetic meter or blood sugar log
- Current list of all medications with the dosage
- Last lab results & office notes from the doctor that referred you
- Insurance card(s) and photo ID

Please arrive 20 minutes before your appointment time. Any co-pay, deductible or co-insurance will be collected at time of service. If you have any questions, please feel free to call the office at the number listed above.

Sincerely,
Eagle's Landing Diabetes & Endocrinology

Appointment Date: _____/_____/_____ Appointment Time: _____: _____am/pm

Rendering Provider

___ R. Watts M.D. ___ C.Plunkett FNP __ D.Crowder FNP

Directions

Traveling on 75 South
-Exit 224; turn left.
-Pass through the 5th light.
-Proceed in left turn off lane.
-We are located on the lower level behind the Depoe Eye Center, Suite 108 & 110.

Traveling on 75 north
-Exit 224; turn right.
-Pass through the 5th light.
-Proceed in left turn off lane.
-We are located on the lower level behind the Depoe Eye Center, Suite 108 & 110.

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Patient Name: _____ **Date Of Birth:** ____/____/____

I authorize the following organization to release information as stated below from the patient health information record:

Information to be Released FROM	***Information to be Released TO***
_____ Name of Organization	Eagles Landing Diabetes and Endo Name of Organization
_____ Phone Number	770-389-9494 Phone Number
_____ Fax Number	770-357-2511 Fax Number

Information to be Released

Dates of service for records request: Beginning _____ **Thru** _____

- o Lab/Pathology Report
- o Clinic Notes
- o Ultrasound Reports/Imaging
- o Other: _____

Purpose of Release

- o Continuing Care
- o Specific Request _____

Authorization for General Release of Information

I understand that:

- Authorizing the disclosure of the healthcare information is voluntary. I do not need to sign this form to assure treatment.
- I can cancel the authorization at any time by writing to Eagles Landing Diabetes and Endo. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

This authorization will expire 12- months from the date signed below unless another date or event is entered here _____

Date: _____

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PATIENT INFORMATION				
DATE:				
Please print clearly. ***All sections must be complete, or your insurance will not be filed***				
Name:		**M or F**	**Age:**	**DOB:**
Last Name	**First Name**	**Middle**		
****Social Security number:**				
Primary phone #				
Address:				
City:	**State:**	**Zip:**		
Patient is under 18 years of age: **YES** **NO** ****If yes, you are patient's:** **Parent** **Legal Guardian** **Other Relation to patient:**				
Patient's Employer:		**Occupation:**		
Referring Doctor:		**Office #**	**Fax #**	
Primary Care Doctor:		**Office #**	**Fax #**	
In case of an emergency who should be notified. **Name:** Telephone # Relation:				
Insurance Carrier:	**ID#:**	**Group #:**		

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I have insurance coverage, or carry insurance coverage for my dependent and assign all insurance benefits payable to Eagle's Landing Diabetes & Endocrinology for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I acknowledge that I am responsible for any collection agency fee, legal or court costs. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission.

Responsible Party Signature **Relationship** **Date**

INFORMED CONSENT

I consent to have Eagle's Landing Diabetes & Endocrinology, including Physician Assistants acting under the supervision of Dr. Watts and the professionals with whom they contract to perform or order examinations, treatment, laboratory tests, imaging tests when necessary such as ultrasounds, MRI, CT scans and x-rays, electrocardiograms, medications, and referrals to other providers when deemed necessary or advisable by the appropriate members of the professional staff and/or consultants in consultation with Eagle's Landing Diabetes & Endocrinology. I understand that by signing this form, I give consent to be seen, evaluated and prescribed medications by Nadine Henry-Ladge MSN, APRN,NP-C, and Hansel M. Rayner,PA-C, FASEPA. This does not mean that I will never see Dr. Watts, but it allows my care to be followed by both the Doctor and the Physician Assistant. I also acknowledge that I have been informed of my rights under Georgia law to have prescriptions reviewed by Dr. Watts before filling it at the pharmacy. This statement has been fully explained to me and I understand it.

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Signature Date

Name:	M or F	Age:	Date of Birth:

Pharmacy Information

Pharmacy Name & City (local):	*Phone#*
E-Med History Request Consent: Yes No	

List Medical History (i.e. Diabetes, thyroid (hyperthyroid, hypothyroid, goiter), high blood pressure or cholesterol, stroke, heart attack, heart or kidney problems), cancer	*Date of Onset*

Past Surgical History (i.e. hysterectomy, heart surgery, gallbladder or appendix removed, amputations)	*Date*

Allergies	**No known drug allergies** **YES** If yes, list drug allergies:

Family History -The following medical problems run in the family (**circle** all that apply):			
Diabetes	Yes	No	Diabetes Type 1 or Type 2
High Blood Pressure	Yes	No	
Heart Problem	Yes	No	Heart attack (if yes, indicate age it occurred _____)

Thyroid disorder	Yes	No	Hyperthyroid, hypothyroid, thyroid cancer, goiter, other:
Stroke \'	Yes	No	
Cancer	Yes	No	Location of cancer:
Tuberculosis	Yes	No	
Others not listed:			

Social History		
Smoke	**No**	**YES,** # of packs/day: _____ for _____ years. **YES**, but I **quit** _____ years ago.
Drink Alcohol	**No**	**YES, oz's per day** _____

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Medication Log

Please complete this medication log before you arrive for your appointment. To get the most accurate information we ask that you gather all your medication bottles and transfer the information form the bottles to this form.

PLEASE PRINT

Medication	Dosage	Quantity	Frequency	Notes

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/01/2003) and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, or $ 20 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Telephone: 770 389-9494 Fax: 770 357-2511 Address: 550 Eagles Landing Parkway, Suite 302. Stockbridge, GA 30281

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ have received a copy of this office's Notice of Privacy Practices.

_____ _____

(Signature) (Date)

Patient Financial Policy

Thank you for selecting our practice as your healthcare provider. We are committed to providing you with compassionate & quality medical care. The following is a statement of our financial policy, which we require you to read, sign and date prior to any treatment.

Payment

All Co-pays, deductibles, co-insurance and non-covered procedures are due in full at time of service. Without a proof of insurance coverage, payment in full for all services provided is required.

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Insurance

It is your responsibility to provide our practice with the accurate and updated medical insurance that should be used to cover service rendered each visit. Please disclose any secondary insurance information if you are covered under more than one insurance plan or any changes in your coverage. Failure to do so may result in you being responsible for the balance on your account. Your insurance policy is a contract between you and your insurance carrier. It's your responsibility to verify benefits with your insurance company prior to your appointment. Should your insurance company fail to pay the insurance claim for services rendered by ***Eagle's Landing Diabetes and Endocrinology*** you may be responsible for the entire charges submitted to the insurance carrier. Co-insurance and any balances that remain the responsibility of the patient, according to the insurance carrier terms, should be remitted to the practice upon notice of balance due. ***Failure to remit payment may result in your patient account being turned over to an outside collection agency. Any accounts turned over to an outside collection agency will incur the collection agency fees and these fees will become the responsibility of the patient.***

Non-Insured Patients

For patients with no insurance we do provide discounted rates on all our services. ***A discounted rate plan is available upon request.***

Missed Appointment

Please help us serve you better by keeping scheduled appointments. In the event you are unable to keep your appointment, kindly give a 24-hour notice. Failing to provide notice of cancellation will result in a $85.00 no show fee. This charge is the responsibility of the patient and most insurance carriers do not cover it.

Forms

Disability, Life insurance and other forms are often requested to be completed by the practice. Many of the forms require review by the physicians and completion of detailed medical history questionnaires. Please allow 3-5 business days for completion of any requested forms. A fee of 35.00 must be pre-paid before forms are completed. We only transfer responsibility to you after we have had a response from your insurance carrier. If you have any questions about your medical coverage, you should contact your insurance company. Never ignore a bill simply because you feel it is not your obligation or you think your insurance company should pay it. If you have questions regarding your bill or wish to set up payment arrangements, please call our billing office at (770) 389-9494. For your convenience, our practice accepts Visa, MasterCard, Discover, American Express, Cash and Personal Checks. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. I have read and agree to abide by the financial policy of ***Eagle's Landing Diabetes and Endocrinology.***

X_____ _____

Signature of Patient or Responsible Party Date

Print Name: _____

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Office Policy

Office Hours

Our normal business hours are Monday through Thursday from *8:00 AM* to *5:00 PM* and closed for lunch from *12:00 PM* to *1:00 PM*. We are open on Friday from *8:00 AM* to *12:00 PM*.

Lab Work:

We are requiring all patients to have lab work done one week prior to your scheduled appointment to see the provider. This allows the provider to have your lab results at the time of your office visit in order to make any necessary changes to your health care plan.

Office laboratory walk-in hours (no appointment necessary) are Monday - Thursday from ***8:00 am to 11:00 am and 1:00 pm to 4:00 pm.*** The in-office lab is closed on Friday for walk in labs. If you would like to have your labs done at a LabCorp or Quest facility for your convenience, we will provide you a paper requisition that you may take with you to have lab work completed. Please note that if your lab work is not done three (3) days prior to your appointment we will reschedule your appointment until you get your labs performed either in office or an outside facility. ***New Patients are not required to have the lab work done a week before your appointment. When you return for your follow up appointment then you will follow this policy.***

Phone Calls

We are a specialty group managing and treating patients with complex endocrine medical problems. Thus, our volume of calls and the complexity of the calls are greater than most medical offices. Please be patient and understand that most incoming calls generally go to a voicemail while we are attending to patients in the office. Phone messages received before 1 PM are generally returned the same day. Otherwise, returns call are within 24 hours of when the message was left.

If lab tests were ordered, we will review and call you ***if test results are critical***. Otherwise, laboratory test results are discussed with patients at the next office visit. ***We will not discuss normal lab results over the phone.***

Cancellation

If you cannot make your scheduled appointment, you must contact our office at least *24 hours* in advance so that we may offer this appointment slot to another patient. There is a *$85 No-Show* cancellation fee that is charged if an appointment is not cancelled in timely manner. This fee must be paid before another appointment will be scheduled for you. Patients that have "no-showed" with our office 2 consecutive times will be referred back to their PCP and will no longer be scheduled with our office.

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Prescription Refills

For your protection, we will no longer refill medications outside of office hours and we will no longer prescribe medication outside of your endocrine needs. If we have prescribed other medications for you in the last year we will give you one 30-day supply.

1. *All refills should be completed at the time of your visit*. Carry an active list of your current medications to each visit. Your medications will be updated in your chart at every appointment. Always check with your pharmacy for refills. Bring a list of needed refills. Keep in mind; ***we will not refill medications that we did not originally write.***

2. *Refill requests will be done only during normal business hours*. If you need a refill, please have your pharmacy call or fax us a request during normal business hours Monday through Thursday 8am-5pm and Fridays up to 12pm for prescription refills. Directly communicating through your pharmacist avoids errors in prescription name, dosage and quantity requested. If you use mail order pharmacy, prescriptions can be written and completed at your appointment.

3. *Prescription request require at least 48 hours for processing of any refill requests.* Therefore, please request refills **in advance** before you are out of your medication so we have time to properly process your request. Remember that you must keep your office visits current to continue to have your medications refilled. It could be very dangerous for us to refill your medications if you have not had a recent office visit. If you have not seen your physician for some time, it is necessary for you to come in for a visit and/or to obtain some laboratory tests before the doctor can refill your medication.

4. *Prior authorizations for medications take up to 2 weeks*. Insurance prior authorizations for medication are done as quickly as possible but these can be very time-consuming for the nurses. Please be patient and allow **at least 2 weeks** to be completed

5. *BRAND NECESSARY drugs verses PREFERRED drugs*. Occasionally, your insurance company will request that your medication be changed to the "PREFERRED" drug to help with costs. We are sympathetic to the goal of saving money, but these types of decisions must be made at an office visit to avoid potential for harm. We believe that no medication should be changed without discussing the action of the medication and potential side effects with you. NOTE: We may approve of generic medications if they are comparable. This usually does not include thyroid hormone.

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Medication Sample Policy

Eagles Landing Diabetes & Endocrinology accept sample medications from pharmaceutical drug representatives and dispense them to our patient population. The distribution of sample medication allows patients a "trial run" on new medication without financial expense. Although the samples are free-of-charge, this does not lessen the physician's continuing responsibility to the patient. Please understand that our providers and staff do not know the details of your prescription drug benefits. Occasionally, your insurance company will request that your medication be changed to the "PREFERRED" drug to help with costs. We are sympathetic to the goal of saving money, but we also believe that no medication should be changed without discussing the action of the medication and potential side effects with you. NOTE: We may approve of generic medications if they are comparable.

Our sample policy is as follows:

- If you are starting a new medication, we will give you two (2) weeks of samples
- If you are currently on a medication that we have prescribed, we will give you two (2) weeks of samples once every 90 days and call a prescription into your pharmacy.

X_____ _____

Signature of Patient or Responsible Party Date

Print Name: _____

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HIPAA Consent Release

New Federal Regulations require us to have your permission to discuss your treatment, personal information or anything pertaining to you with anyone other than yourself. If a person's name is not listed on this form, we cannot discuss your information with anyone unless in an emergency.

Please Review and Then Sign in One of the Areas Below:

I hereby ***give my consent*** to Dr Ronald S. Watts, MD, Hansel Rayner, PA-C and Nadine Henry-Ladge, NP and their staff to review or discuss my medical treatment, lab results, pathology reports, medication changes, personal or financial information etc. to the following persons **OTHER THAN MYSELF** (i.e. spouse, parent, child etc.)

1._____RELATIONSHIP _____ Phone _____

2._____RELATIONSHIP_____ Phone_____

3._____RELATIONSHIP_____ Phone_____

Patient Signature _____ Date _____

I ***do not want any type of information discussed with anyone other than myself **

Patient Signature _____ Date _____

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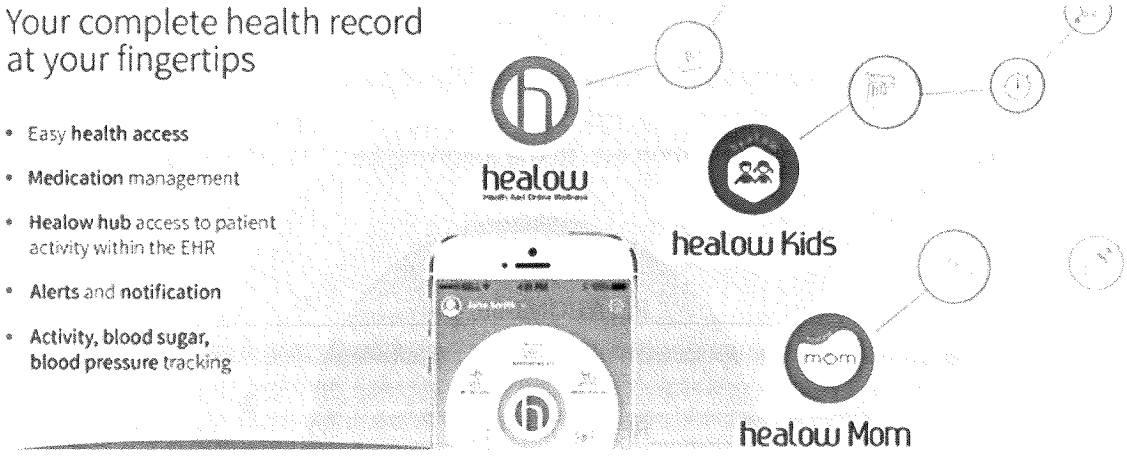
healow
Health And Online Wellness



We are pleased to announce our patient health portal "Healow". The patient portal will facilitate a better way to communicate with your physician's office by providing convenient and secure access from the comfort and privacy of your home. In order to access this feature please sign below and provide us with your valid email address.

Email Address: _____@_____. _____