PATIENT INFORMATION

Last Name	First Name	M.I

Street Address	City	State	Zip
Mailing Address (if not same as above)	City	State	Zip

Home ph #	Work ph #	Cell #

Birthday(mm/dd/yy)	Sex: M F	SSN:	Driver's license # and state

Email Address:	Martial Status: Single____ Married____ Divorced____ Widow/Widower____
Race: White ____ African American____ Hispanic____ East Indian ____ Southeast Asians ____ Other ____	Ethnicity: Language:
Employer	Employer Phone
Primary Care Physician: (PCP)	PCP Telephone #:

EMERGENCY CONTACT

Name	Relationship	Telephone # ( )

Address	City	State	Zip

INSURANCE INFORMATION

Insurance Company	Policy Holder's Name	Birthday	SSN

Member ID Number	Group Number	Employer

Patient relationship to Insured: Self Spouse Child Other:

Additional Insurance Company	Policy Holder's Name	Birthday	SSN

Member ID Number	Group Number	Employer

Patient relationship to Insured: Self Spouse Child Other:

HOW DID YOU HEAR ABOUT US?

□ Referred By □ Ins. Directory □ Friend □ Yellow Pages □ Direct Mail □ Physician □ LA Fitness

Referral's Name	Referral Phone Number ( )

I _____DO _____DO NOT (Please initial) **GIVE PERMISSION TO HAVE MY HEALTH INFORMATION SHARED WITH MY CHILDREN AND SPOUSE OR: _____.**

Do you currently have an Advanced Directive? Please list the responsible party for this document _____

AUTHORIZATION FOR RELEASE OF INFORMATION- I hereby authorize this practice to furnish any medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment of my care.

ASSIGNMENT OF BENEFITS- I hereby authorize payment directly to this practice of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefit, but not excess the charges for these services understand that I am financially responsible for charges not covered by this assignment.

GUARANTEE OF ACCOUNT- For service furnished by Atlanta Heart Specialists, LLC., I hereby guarantee the payment of all account for service rendered. For payment of said accounts for service I hereby waive all claims of exemption under the State Of Georgia to pay, if necessary, all costs of collection, including attorney's fee.

Signature _____ Date _____

ATLANTA HEART SPECIALISTS, LLC

David H. Song, M.D., FACC
Linda G. Yan, M.D., FACC
Anthony Dorsey, M.D., FACC
Zoubin Alikhani,MD
Mark Schneider, DO, FACC, FSCAI
Sandeep Chandra, M.D., FACC
David D. Suh, M.D., FACC
Binu Kunjummen, MD
Osman Ahmed, MD, FACC
Mussie Gebremedihn, MD
Bakhtiar Ali, MD
Jose A. Torres, MD
Jawahar Gazzala, MD
Ghazanfar Qureshi, MD
Michael Morris II, MD

MEDICAL INFORMATION SHEET

DATE: _____

Full Name: _____ Birth date/Age: _____
(First) (Middle) (Last)

Who referred you? _____ Phone_____ Fax_____

Primary Care Doctor: _____ Phone _____ Fax _____

List primary concerns relating to your heart: _____

_____

What cardiac-related tests have been done previously?

Date	Test	Where Done	Result

_____

_____

PLEASE ANSWER EACH QUESTION TO ENSURE PROPER EVALUATION AND TREATMENT

Do you have:

history of previous heart attack?	Yes	No
prior balloon angioplasty or coronary stents?	Yes	No
prior open heart surgery?	Yes	No
congestive heart failure?	Yes	No
high blood pressure?	Yes	No
high cholesterol?	Yes	No
diabetes mellitus?	Yes	No
family history of heart disease?	Yes	No

If yes, please list _____

Do you:

currently smoke cigarettes?	Yes	No
Packs per day _____ x_____ years		
If you've quit, when? _____		
drink alcohol?	Yes	No
Amt per week _____ x _____ years		
use illegal drugs?	Yes	No
Specify _____		

Are you:

allergic to shellfish?	Yes	No
sensitive to IV dyes?	Yes	No
sensitive/allergic to medications?	Yes	No

Please list allergies or sensitivities below:

_____

_____

MEDICAL INFORMATION SHEET (Continued)

Please list all medications, herbs, and vitamins that you are currently taking:

Medicine/Herb	Dose (mg)	Frequency	Medicine/Herb	Dose (mg)	Frequency

Please list all medical problems

Please list all previous surgeries (with date & place)

Do you get chest pressure, pain, or discomfort?	Yes	No
Do you take Nitroglycerin for chest discomfort?	Yes	No
Do you ever get short of breath?	Yes	No
Is your breathing worse while lying down?	Yes	No
Do you get palpitations, heart racing or skipped heartbeats?	Yes	No
Do you get swelling in your legs or feet?	Yes	No
Do you get pain in your legs when you walk?	Yes	No
Do you feel dizzy or lightheaded?	Yes	No
Have you passed out/fainted recently?	Yes	No
Have you had fever/chills recently?	Yes	No
Have you had weight loss recently?	Yes	No
Have you had headaches recently?	Yes	No
Have you had dark or bloody stools recently?	Yes	No
Do you snore?	Yes	No
Do you feel weak or get tired easily?	Yes	No

Please specify any physical limitations _____

_____

Please check appropriate boxes: ☐ Single ☐ Married ☐ Divorced

☐ Employed ☐ Unemployed ☐ Disabled

Where do you work? _____ Phone: _____

What type of work do you do? _____

Ethnicity: _____ Language: _____ Race:_____

Please give your home phone number and one additional contact name and number:

Home: _____ Additional: _____

ATLANTA HEART SPECIALISTS, LLC

FINANCIAL POLICY

We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines:

1. You are ultimately responsible for payment of ALL charges for services received from our office.
2. Our office will verify benefits for office visits and testing but we rely greatly on the information given to us by your insurance. If you believe that a deductible and co-insurance will apply to any of services provided by Atlanta Heart, please contact your insurance company for a confirmation. **It is the responsibility of the patient to know what their insurance benefits are for any given test, office visit or labs**.
3. Our office will provide you with an estimate of your responsibility, upon request. These **quotes are estimates only** and may be more or less after your insurance company has processed your claims.
4. If you have been notified by our office that your insurance has approved your testing, this does not guarantee that your insurance company will pay the test at 100%. Deductible and co-insurance still applies.
5. It is your responsibility to provide us with your current address, telephone number and insurance information at each visit.
6. Medicare patients, please keep us updated with your most current Medicare HMO Plan.
7. It is your responsibility to contact your insurance carrier to confirm that the doctor you are seeing is a participant of your plan. If you see a doctor that is not currently on your plan, we will bill you for that date of service. Upon receipt of payment from your insurance company any unpaid balance will be your responsibility.
8. If your plan requires a referral from your primary care physician we will try to obtain one for you but you are ultimately responsible for knowing if we have received a referral or not. If we do not receive a referral from your primary care physician you will be billed for services provided.
9. **No study will be performed** until financial arrangements have been made with the billing office and all balances have been paid off!!! A 50% deposit is required at the time of service for all testing.
10. **Our office charges a $25.00 for a returned check.**
11. We will mail you a monthly statement for any outstanding balance. If your insurance carrier has not paid within 30 days for the date of service, PLEASE contact your carrier and assist us in getting the claim paid.
12. SELF PAY: You must bring the full amount due to your first visit. A 50% deposit is required at time of services for all tests scheduled. Payment plans are offered for the remainder of the balance only.
13. We will try our best to assist you any way possible with your bills. Any balance that is over 90 days old will be transferred to an outside collections agency for credit reporting. A patient that has been placed in collections must pay any prior balance owed to the practice, **COLLECTION AGENCY FEES** and any attorney fees in cash before the practice will schedule any future appointments.
14. If you are experiencing financial difficulties that will make the payment of our charges difficult for you, please contact one of our Patient Account Representatives at (770) 638-1400. Please do not leave a message as someone will be able to help you at the time of your call.

If you cannot make a payment in full on your **existing balance ONLY** (payment plans do not apply to future visits or tests) our payment schedule is as follows:

BALANCE	PAYMENT PER MONTH	BALANCE	PAYMENT PER MONTH
0 - $99	$25.00	$1000 - $2500	$200.00
$100 - $499	$50.00	$2500 - $5000	$300.00
$500 - $999	$100.00		

I acknowledge that I understand and accept this financial policy as a patient at Atlanta Heart Specialists.

_____ _____ _____

Signature **Date** **Relationship to Patient**

1/14/2015

ATLANTA HEART SPECIALISTS, LLC

1468 MONTREAL ROAD, TUCKER, GA 30084, PH: 770-638-1400, FAX: 770-638-1411
4375 JOHNS CREEK PARKWAY, STE 350, SUWANEE, GA 30024, PH: 770-622-1622 , FAX: 770-622-1627
5910 HILLANDALE DR, STE 350, LITHONIA, GA 30058, PH: 678-578-8900, FAX: 678-578-8905
3275 MARKET PLACE BLVD, SUITE 100, CUMMING, GA, PH: 678-679-6800, FAX: 678-679-6804
2665 N. DECATUR RD, STE 320, DECATUR, GA 30033, PH: 404-856-3550, FAX:404-856-3557
5667 PEACHTREE DUNWOODY RD, STE 390, ATLANTA,GA 30342, PH:470-225-6117, FAX:470-225-6120
4120 FIVE FORKS TRICKUM RD, STE 103, LILBURN, GA 30047, PH:770-255-3491, FAX: 770-255-3497
771 OLD NORCROSS RD, STE 310, LAWRENCEVILLE, GA 30046, PH: 770-513-5999, FAX: 770-513-5994

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Ghazanfar Qureshi MD, Mark Schneider, DO, FACC, FSCAI, Mussie Gebremedihn, MD, Michael Morris II, MD

PATIENT COMMUNICATION PREFERENCE

I authorize the following persons to have full access to my health information:

_____	_____	_____
Name of Contact (Please PRINT)	**Relationship to patient**	**Date**
_____	_____	_____
Name of Contact (Please PRINT)	**Relationship to patient**	**Date**
_____	_____	_____
Name of Contact (Please PRINT)	**Relationship to patient**	**Date**

I, _____ give my permission for you to leave any medical or laboratory

information regarding my health information at the following:

Home Phone: _____
Mobile Phone: _____
Work Phone: _____
Email: _____
Mailing Address: _____
_____

I, the undersigned, give my permission for Atlanta Heart Specialists, LLC, to disclose my health information as described herein. Any changes to my communication preferences must be submitted in writing. Atlanta Heart Specialists is released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____	_____	_____
Signature of Patient or Legal representative	**Relationship to patient**	**Date**

ATLANTA HEART SPECIALISTS, LLC

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Ghazanfar Qureshi MD, Mark Schneider, DO, FACC, FSCAI, Mussie Gebremedihn, MD, Michael Morris II, MD

Authorization for Disclosure of Health Information

Name Patient	Date of Birth	Phone Number	Medical Record Number

1. I hereby authorize Atlanta Heart Specialists, L.L.C. to: **(√ Check One)** _____ disclose information to OR _____ obtain information From:

_____
(Name of Person or Organization)

_____
(Phone Number) (Fax Number)

_____
(Address for above) or (**additional** Name of Person or Organization to be given authorization)

2. This information is to be disclosed for the period(s) of healthcare:(date) _____ to (date)_____

Information To Be Disclosed (Please Check √)

_____ **Entire Record** _____ X-Ray Reports _____ Cardiac Cath Report _____ Laboratory Tests
_____ Stress Test Report _____ Office Notes _____ EKG _____ Echo Report
_____ DVD, digital, or other Other (please specify) _____

4. _____ I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric (Patient's initials) HIV testing, HIV results, or AIDS information.

5. I understand this authorization may be revoked by me in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in 12 months following the date signed.

6. RESEARCH: Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' needs for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave Atlanta Heart Specialists, LLC. We will almost always ask for your specific permission if the researcher will have access to your name or other information that reveals who you are, or will be involved in your care at Atlanta Heart Specialists, LLC

7. I have been given a copy of the Atlanta Heart Specialists, LLC, HIPPA policy and E-Prescribe notification.

I, the undersigned, have read the above and authorize Atlanta Heart Specialists to disclose such information as herein contained. This office is released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected.

_____ _____ _____
Date **Signature of Patient or Legal Representative** **Relationship to Patient**

ATLANTA HEART SPECIALISTS, LLC

Sandeep Chandra, MD, FACC; David Song, MD, FACC; Linda Yan, MD, FACC; David Suh, MD, FACC; Anthony Dorsey, MD, FACC; Jawahar Gazzala, MD; Michael Morris III, MD; Jose Torres, MD; Osman Ahmed, MD; Zoubin Alikhani, MD; Ghazanfar Qureshi, MD; Binu Kunjummen, MD ; Mussie Gebremedihn, MD; Mark Schneider, DO,FACC

Vascular Disease Patient Questionnaire

Patient:_____ Date:_____

DOB:_____ Age:_____ Sex: Male_____Female_____

Yes No 1. Do you smoke or have a history of smoking?
Yes No 2. Do you have diabetes or have a family history of diabetes?
Yes No 3. Do you have high cholesterol?
Yes No 4. Do you have high blood pressure / hypertension?

CEREBRAL VASCULAR *Have you experienced:*

Yes No 5. Any changes in your vision such as a loss of vision in one or both eyes for a period of time?
Yes No 6. Sudden weakness / numbness on one side of your body?
Yes No 7. Lose the ability to talk or write, or your speech was garbled / slurred?
Yes No 8. Recurrent lightheadedness, or near fainting with head motion, migraine headache, dizziness?
Yes No 9. Mini-stroke or TIA?

PERIPHERAL VASCULAR

Yes No 10. Do you have a foot, calf, buttock, hip or thigh discomfort (aching, burning, fatigue, tingling, cramping or pain) when you walk which is relieved by rest?
Yes No 11. Do you have any pain in your feet at night that is only improved with standing?
Yes No 12. Are your feet always cold?
Yes No 13. Is your feet bright red in color, or pale, discolored or bluish?
Yes No 14. Do you have any ulcers / sores, or wounds on your feet / toes that difficult to heal?
Yes No 15. Have you needed or had surgery to improve leg circulation?
Yes No 16. Have you had any leg circulation tests done recently?

ANEURYSMAL DISEASE

Yes No 17. Do you have a known Aneurysm?
Yes No 18. Has anyone in your family ever been diagnosed as having an aneurysm?
Yes No 19. Do you have a pulsing feeling in your abdomen similar to a heartbeat?

VENOUS DISEASE

Yes No 20. Do you have leg swelling/edema?
Yes No 21. Do you have varicose veins?
Yes No 22. Do your legs feel heavy, tired, achy, tender, warm, and burning?
Yes No 23. Have you ever had an open sore between your knee and ankle that took a long time to heal?

Patient Signature_____