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 – REVIEW OF SYSTEMS (to be filled out if not done in the past 3 months)

NAME _____ DATE _____

PLEASE INDICATE BELOW. ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS:

General, constitutional

Good general health lately	no	yes
Recent weight change	no	yes
Fever / chills	no	yes
Fatigue	no	yes

Eyes and vision

Eye disease or injury	no	yes
Wear glasses or contact lenses	no	yes
Blurred or double vision	no	yes
Glaucoma	no	yes

Ears, nose, throat

Hearing loss	no	yes
Ringing in the ears	no	yes
Sinus problems	no	yes
Nose bleeds	no	yes
Bleeding gums	no	yes
Sore throat or voice change	no	yes

Genitourinary

Frequent urination	no	yes
Burning or painful urination	no	yes
Blood in urine	no	yes
Sexual difficulty	no	yes
Irregular periods	no	yes

Respiratory

Frequent coughing	no	yes
Spitting up blood	no	yes
Shortness of breath	no	yes
Asthma or wheezing	no	yes

Gastrointestinal

Loss of appetite	no	yes
Constipation	no	yes
Nausea or vomiting	no	yes
Frequent diarrhea	no	yes
Blood in stool	no	yes
Stomach pain	no	yes

Musculoskeletal

Joint pain	no	yes
Joint stiffness or swelling	no	yes
Weakness of muscles/joints	no	yes
Muscle pain or cramps	no	yes
Back pain	no	yes
Difficulty in walking	no	yes

Skin and breasts

Rash or itching	no	yes
Change in skin color	no	yes
Varicose veins	no	yes
Breast pain	no	yes

Neurological

Frequent or recurrent headaches	no	yes
Lightheaded or dizzy	no	yes
Convulsions or tingling sensations	no	yes
Tremors	no	yes
Strokes / TIA	no	yes
Head injury	no	yes

Psychiatric

Memory loss or confusion	no	yes
Nervousness / anxiety	no	yes
Depression	no	yes
Sleep problems	no	yes
Snoring	no	yes

Endocrine

Glandular or hormone problem	no	yes
Thyroid disease	no	yes
Diabetes	no	yes
Excessive thirst or urination	no	yes
Heat or cold intolerance	no	yes

Hematologic / Lymphatic

Slow to heal after cuts	no	yes
Easily bruise or bleed	no	yes
Anemia	no	yes
Phlebitis	no	yes
Transfusion	no	yes
Swollen glands	no	yes

Any other problems not yet identified? Please note

AHS – NEW PATIENT VISIT FORM

(Complete if you have not been seen in over 2 years or are seeing MD for the first time)

Name _____ DOB _____ Age_____

Male _____ Female _____ Referring Dr_____

Why are you here? Any specific questions for the doctor?

- _____
- _____
- _____

CARDIAC HISTORY:

Any recent heart tests? If yes, please notify the staff to request copies of the reports
□ Echo (cardiac ultrasound) □ Stress test □ Nuclear stress test □ Heart Cath
□others_____

Do you;			
Have High blood pressure	yes	no	# of yrs_____
Have High cholesterol	yes	no	# of yrs_____
Have Diabetes	yes	no	# of yrs_____
Smoke	yes	no	# of yrs_____quit when? _____
Drink alcohol	yes	no	# of yrs_____amt/week?_____
Exercise at least 3x/week	yes	no	what activity?_____
Have previous heart attack	yes	no	when? _____
Have Previous Stroke	yes	no	when? _____
Have previous heart surgery	yes	no	when? _____
Have previous vascular surgery	yes	no	when? _____
Get chest pains/pressure	yes	no	describe_____
Get dizzy or faint	yes	no	describe_____
Get racing heart/skip beats	yes	no	describe_____
Get shortness of breath	yes	no	describe_____
Get leg swelling	yes	no	describe_____
Had a heart murmur?	Yes	no	describe_____

Current medication list (include herbs/supplements and doses)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Current allergy list

_____ _____
_____ _____
_____ _____

Shellfish allergy yes no **IV dye allergy** yes no

PAST MEDICAL HISTORY:

List all surgeries and year.

_____ _____
_____ _____
_____ _____

List all other hospitalizations and year.

_____ _____
_____ _____
_____ _____

Any other ongoing medical problems?

_____

FAMILY HISTORY:

Any family History of heart disease? Who?

Relation_____ Condition_____
Relation_____ Condition_____
Relation_____ Condition_____

Mothers age_____ If deceased, cause of death_____
Fathers age_____ if deceased, cause of death_____
Siblings? Yes No #_____ Any health Issues? _____

PSYCHO-SOCIAL HISTORY:

Where were you born? _____ Your Ethnicity_____

Are you? □ Single □ married □ divorced □ widowed □ common law partner

Are you? □ employed □ unemployed □ disabled □ retired □ student

Where do or did you work? _____

Describe your current or past job_____
_____

Do you have children? Yes No Ages_____
_____

Are you under any unusual stress? Yes No Please describe below?

VASCULAR SCREENING:

1. Pain, burning, aching in your legs when walking? Yes No
2. Pain or cramping in the back of your legs when walking? Yes No
3. Are there ulcers or sores on your legs? Yes No
4. Have you needed or had surgery to improve leg circulation? Yes No
5. Have you needed or had stents to improve leg circulation? Yes No
6. Have you ever been told you have an aneurysm of a vessel? Yes No
7. Have you had any leg circulation tests done recently? Yes No
8. Have you ever had a mini-stroke or TIA? Yes No
9. Have you ever had a blood clot in legs or lungs? Yes No

Name_____ Signature_____ DATE _____

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 _____

7/29/2011

ATLANTA HEART SPECIALISTS, LLC

TUCKER:	PH: 770-638-1400.	FAX: 770-638-1411.	1468 MONTREAL RD EAST. TUCKER. GA 30084.
JOHNS CREEK:	PH: 770-622-1622.	FAX: 770-622-1627.	4375 JOHNS CREEK PARKWAY. STE 350. SUWANEE. GA 30024.
CUMMING:	PH: 678-679-6800.	FAX: 678-679-6804.	1505 NORTHSIDE BLVD. STE 2500. CUMMING. GA 30041.
DMC LITHONIA:	PH: 678-578-8900.	FAX: 678-578-8905.	5910 HILLANDALE DR. STE 350. LITHONIA. GA 30058.
DMC DECATUR:	PH: 404-856-3550.	FAX: 404-856-3557.	2665 N. DECATUR RD. STE 320. GA 30030.

David H. Song, MD, FACC; Sandeep Chandra, MD, FACC; Linda G. Yan, MD, FACC; David D. Suh, MD, FACC; Anthony Dorsey, MD, FACC; Narendra Singh, MD, FACC; Osman Ahmed, MD, FACC; Tenecia Allen, MD; Zoubin Alikhani, MD, FACC; Binu Kunjummen, MD; Bakhtiar Ali, 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

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.

Date	Signature of Patient or Legal Representative	Relationship to Patient

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
1505 NORTHSIDE BLVD. STE 2500, CUMMING, GA PH: 678-679-6800 FAX: 678-679-6804
2665 N. DEACTUR RD, STE 320, DECATUR, GA 30033 PH: 404-856-3550 FAX:404-856-3558
5669 PEACHTREE DUNWOODY RD, STE 345, 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, 770-513-5999, FAX: 770-513-5994

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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)

_____
(Phone Number) (Fax Number

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	_____ Videotape, digital, or other

Other (please specify) _____

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