



Winston H. Gandy, Jr., M.D., F.A.C.C., F.A.S.E

5730 Glenridge Drive, Suite 220

Atlanta, GA 30324

Phone: (404)796-7011 Fax: (404)796-7099

PATIENT INFORMATION

First Name _____ M.I. _____ Last Name _____

Sex: Male Female Date of Birth ____/____/____ SSN _____

Marital Status: M S W D Race _____ Language _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Refuse to report

Email: _____ Patient Portal Access: Y N

Mailing Address: _____

City _____ State _____ Zip Code _____

Home Phone _____ Work _____

Cell _____ Preferred: Home Cell Work

Employer _____ Occupation _____

Employment Status Disabled Not employed Full-time
 Part-time Self-employed Retired Student

Primary Insurance _____ Secondary Ins _____

Primary Care Physician (PCP) _____ Phone _____

Referring Provider/Individual/Source _____

Pharmacy _____ Phone _____

Emergency Contact _____ Relationship _____ Phone _____

Can medical records and your health information be released to the emergency contact provided? YES NO

Assignment of Benefits I hereby authorize my insurance company to make payments to this practice for medical or surgical services or items rendered to me or my dependent. Should my insurance carrier deny payment, I understand that I am financially responsible for charges. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information. **Release of Information** I authorize this practice to release any and all of my records to my insurer, or any third party payer, legally responsible for the payment of medical expenses.

Guarantee of Account – For services furnished by Atlanta Cardiology Associates, LLC., I hereby guarantee the payment of all account for services 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 _____



Winston H. Gandy, Jr., M.D., F.A.C.C., F.A.S.E

5730 Glenridge Drive, Suite 220

Atlanta, GA 30324

Phone: (404)796-7011 Fax: (404)796-7099

CONSENT FOR TREATMENT

1. I consent to the rendering of medical treatment/services as considered necessary and appropriate by my physician and/or designated staff. The consent to receive medical treatment/services includes but is not limited to: initial evaluations, assessment evaluations, examination (EKG or otherwise), laboratory services/procedures, medications, patient education, and other services in which patient will receive. _____(Initials)
2. I hereby authorize my physician or designated staff to perform diagnostic studies, as a recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. Diagnostic testing and services may include but is not limited to: echocardiograms, carotid ultrasounds, exercise treadmill test, nuclear stress test, ABI, post exercise ABI, lower arterial, lower venous, abdominal aorta, and other services recommended by your physician. I am aware that there may be material risk associated with these procedures. If I have any questions or concerns regarding any procedure, I will ask my physician to provide me with additional information. _____(Initials)
3. I give my consent to have Atlanta Cardiology Associates obtain my prescription history from external sources. _____(Initials)

FINANCIAL RESPONSIBILITY/OFFICE POLICIES

1. All patients are required to complete a demographic form, which will be used to ensure accurate information for proper billing. In order to validate your coverage, our office must be provided with a copy of your ID and Insurance Card(s). If you fail to provide the office with correct insurance information or insurance changes within a timely manner, you understand that you will be responsible for the balance of any claim(s).
2. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time services are rendered. **I understand that there is a \$50 returned check fee.**
3. I understand that if an insurance referral is required to see a specialist, **it is the patient's responsibility to ensure that the office receives authorization prior to appointment.** If a referral is not obtained, I understand that I will be responsible for the services that are rendered.
4. I understand that there is a standard fee of \$30 for copies of my medical records. Please note that there is no charge for records being sent from physician to physician/medical group/hospital.
5. I understand that there will be a charge to complete any medical forms or draft any letter per the patient's request. Short & Long-term Disability forms are \$25 per document, FMLA is \$50, letters are \$25, notary for handicap parking permits are \$10.
6. I understand that the time frame for forms or letter request(s) to be completed is at least 5-7 business days.

Patient's Signature _____

Date: _____

Legal Guardian's Signature _____

Relationship _____



Winston H. Gandy, Jr., M.D., F.A.C.C., F.A.S.E
Michael Morris II, M.D.
5730 Glenridge Drive, Suite 220
Atlanta, GA 30324
Phone: (404)796-7011 Fax: (404)796-7099

**ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally was offered and/or received a copy of Atlanta Cardiology Associates's Notice of Privacy Practices on the date indicated below.

Signature: _____ Date: _____

Patient: _____

Information about Agent (attach appropriate documentation):

Agent: _____

Title: _____

FOR OFFICE USE ONLY

- Patient/Representative Unable to Sign - Notice of Privacy Practices Provided**
- Patient/Representative Refused to Sign - Notice of Privacy Practices Provided**
- Other** _____

Signature: _____ Date: _____

Print Name: _____



Winston H. Gandy, Jr., M.D., F.A.C.C., F.A.S.E

Michael Morris II, M.D.

5730 Glenridge Drive, Suite 220

Atlanta, GA 30324

Phone: (404)796-7011 Fax: (404)796-7099

Authorization to Release Medical Records

Name of Patient _____ Date of Birth _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

INFORMATION TO BE RELEASED

- History & Physical, Operative Reports, Lab/Path Reports, Consultation Report, Discharge Summary, X-ray, MRI, CT Reports/Images, ER Records, Face sheet, ALL RECORDS, Office notes, Echo, EKG, results, Other

The above information may be released to:

- Winston H. Gandy, Jr., M.D., F.A.C.C., F.A.S.E; Michael Morris II, M.D. 5730 Glenridge Drive, Suite 220 Atlanta, GA 30324 Phone: 404-796-7011 Fax: 404-796-7099

FROM:

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) _____ Phone Number _____

Address (Street, City, State, Zip) _____ Fax Number _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or other treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire 1 year from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____

Signature: _____ Patient or Legally Authorized Representative

Printed Name of Patient or Legally Authorized Representative

Relationship to Patient



Winston H. Gandy, Jr., M.D., F.A.C.C., F.A.S.E

Michael Morris II, M.D.

5730 Glenridge Drive, Suite 220

Atlanta, GA 30324

Phone: (404)796-7011 Fax: (404)796-7099

PATIENT COMMUNICATION CONSENT FORM

I agree to allow Atlanta Cardiology Associates to contact me in the following methods regarding my appointments, prescription notifications, private health information, evaluation, treatment, and billing matters. I authorize Atlanta Cardiology to contact me or leave messages for me when I am unavailable using my preferred method outlined below:

METHOD	NUMBER/ADDRESS	MESSAGE (Yes or No)	
_____ Home Phone	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____ Cell Phone	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____ Text Messages	_____ Same as cell phone _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____ Work Phone	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____ Email	_____ @ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

I authorize Atlanta Cardiology Associates to discuss my health information (which may include history, diagnosis, lab and test results, treatment, and other health information) with the contacts listed below.

NAME	RELATIONSHIP TO PATIENT	CONTACT INFORMATION
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

By my signature below, I acknowledge that a copy of the Notice of Privacy Policies/Bill of Rights for Atlanta Cardiology has been made available to me and I understand the information provided on this consent form. I understand the risk associated with the different methods of communication (especially email), and consent to the conditions, restrictions, and patient responsibilities outlined within the guideline.

Patient's Printed Name

Date

Patient/Guardian Authorized Signature

Date



Winston H. Gandy, Jr., M.D., F.A.C.C., F.A.S.E
Michael Morris II, M.D.
5730 Glenridge Drive, Suite 220
Atlanta, GA 30324
Phone: (404)796-7011 Fax: (404)796-7099

No-Show/Late Cancellation Policy

This policy has been established in order to provide the highest level of care to all of our patients, which will also enable us to better utilize available appointments for our patients in need of care.

Available appointments are in high demand and your early cancellation will allow us to accommodate other patients with your appointment slot.

- Patients who fail to show for their scheduled **office visit** appointment or did not notify the office within 24 hours of their scheduled appointment time, shall be subject to a “No Show/Cancellation” fee of \$50.00.
- Patients who fail to show for their scheduled **diagnostic** appointment(s) (e.g. ECHO, Carotid, Treadmill, etc.) or did not notify the office within 48 hours of their scheduled appointment time, shall be subject to a “No Show/Cancellation” fee of \$75.00.
- Patients who fail to show for their scheduled **Nuclear Stress Test** appointment or did not notify the office to cancel or reschedule within 48 hours of their scheduled surgery appointment time, shall be subject to a “No Show/Cancellation” penalty of \$400.00.
- We do understand that emergencies arise and that it may not be possible to give such a notice, consideration will be given, and a one-time exception may be granted.

Please note that these fees are not covered by insurance and is therefore the sole responsibility of the patient.

Patients will receive telephone, text, or email appointment reminders 48 hours prior to their scheduled appointment and will be given the opportunity to cancel. To cancel or reschedule your appointment(s), call the office 404-796-7011. You may also cancel using your patient portal.

Patient Name: _____ Date of Birth: _____

I, the undersigned, have been scheduled for a diagnostic test on _____ / _____ / _____ at _____: _____ a.m.

Please sign and date below to verify that you understand the cancellation policy stated above.

Signature: _____ Date: _____



HISTORY FORM

Date of Visit: _____

Patient Name: _____

Date of Birth: _____

CHIEF COMPLAINT:

Approximate date of onset: _____ For How long? _____

PAST CONDITIONS/SURGERIES

<i>Past injuries or Medical Conditions</i>	<i>Date</i>	<i>Treating Physician</i>

<i>Past Surgeries</i>	<i>Date</i>	<i>Surgeon</i>

Date of Visit: _____

Patient Name: _____

Date of Birth: _____

PAST MEDICAL/SURGICAL HISTORY

Do you have or have you had any of the following medical conditions? (Please check the corresponding box and/or specify conditions listed)

<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Colon Cancer	<input type="checkbox"/>	Hypertension/High Blood Pressure	<input type="checkbox"/>	Spinal Cord Tumor
<input type="checkbox"/>	Angina	<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	Kidney Failure/Renal Disease	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	Arrhythmia/Irregular heart	<input type="checkbox"/>	COPD- lung disease	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	Tremor
<input type="checkbox"/>	Atrial Fibrillation	<input type="checkbox"/>	Diabetes (<i>List Type</i>):	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	Cancer (<i>List type</i>):
<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	Parkinson's Disease	<input type="checkbox"/>	Heart Disease (<i>Including</i>):
<input type="checkbox"/>	Brain Tumor	<input type="checkbox"/>	Hepatitis C/Liver Disease	<input type="checkbox"/>	Peripheral Nerve Disorder	<input type="checkbox"/>	Murmur
<input type="checkbox"/>	Stroke/Cerebrovascular Accident	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	Bypass Surgery
<input type="checkbox"/>	Cirrhosis of Liver	<input type="checkbox"/>	Hyperlipidemia/High Cholesterol	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Pacemaker
							Mitral Valve Prolapse
							Stent
							Heart Attack

Have you had any of the following surgical procedures listed below? You will have the opportunity to specify surgeries on the following page.

<input type="checkbox"/>	Anesthesia reaction	<input type="checkbox"/>	Carpal Tunnel	<input type="checkbox"/>	Knee Replacement	<input type="checkbox"/>	Tonsillectomy
<input type="checkbox"/>	Aneurysm clipping	<input type="checkbox"/>	Cataract extraction	<input type="checkbox"/>	Laminectomy	<input type="checkbox"/>	C-section
<input type="checkbox"/>	Angioplasty	<input type="checkbox"/>	Cerebral shunt/VP shunt	<input type="checkbox"/>	LASIK	<input type="checkbox"/>	D and C
<input type="checkbox"/>	Appendectomy	<input type="checkbox"/>	Cholecystectomy/Gall bladder removal	<input type="checkbox"/>	Muscle biopsy	<input type="checkbox"/>	Hysterectomy
<input type="checkbox"/>	Arthroscopy knee	<input type="checkbox"/>	Discectomy	<input type="checkbox"/>	ORIF/plating of bone fracture	<input type="checkbox"/>	Mastectomy/Breast Removal
<input type="checkbox"/>	Arthrodesis/Fusion	<input type="checkbox"/>	Gastric bypass	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	Reduction mammoplasty
<input type="checkbox"/>	Back Surgery	<input type="checkbox"/>	Colostomy	<input type="checkbox"/>	Small bowel resection	<input type="checkbox"/>	Myomectomy
<input type="checkbox"/>	CABG/Heart bypass surgery	<input type="checkbox"/>	Hernia Repair	<input type="checkbox"/>	Spinal infusion pump	<input type="checkbox"/>	TAH/BSO
<input type="checkbox"/>	Carotid endarterectomy	<input type="checkbox"/>	Hip replacement	<input type="checkbox"/>	Thyroidectomy	<input type="checkbox"/>	Vaginal Hysterectomy



Winston H. Gandy, Jr., M.D., F.A.C.C., F.A.S.E

Michael Morris II, M.D.

5730 Glenridge Drive, Suite 220

Atlanta, GA 30324

Phone: (404)796-7011 Fax: (404)796-7099

Date of Visit: _____

Patient Name: _____

Date of Birth: _____

FAMILY HISTORY

Have any of your direct relatives or immediate family members been treated for the following conditions? If yes, please check off the condition AND name their relationship to you. Please specify their age and cause of death in the last row.

✓	CONDITION Age of Death →	Mother AOD:	Father AOD:	Sister AOD:	Brother AOD:	Family H/O (Aunts, Cousins, etc.)
	Aneurysm					
	Bleeding Disorder					
	Brain Hemorrhage					
	Cancer (specify type)					
	Heart Disease					
	Lung Disease					
	Stroke					

SOCIAL HISTORY

Do you drink Alcohol? YES NO

Quantity: _____ Bottle(s) Glass(es) Cup(s)

Frequency: _____ weekly daily monthly socially occasionally

Do you Smoke? YES NEVER FORMER: Quit Date _____

How often? _____ How many packs? _____

Do you drink caffeine? YES NO

Quantity: _____ Cup(s) daily

ALLERGIES

Please list any food or drug allergies w/reactions: _____

Date of Visit: _____

Patient Name: _____

Date of Birth: _____

REVIEW OF SYSTEMS

Are you currently experiencing any of the followings? (Please check the corresponding box)

MARK THIS BOX IF YOU ARE NOT HAVING ANY SYMPTOMS

<input type="checkbox"/>	<i>Symptom</i>	<input type="checkbox"/>	<i>Symptom</i>	<input type="checkbox"/>	<i>Symptom</i>
	CONSTITUTIONAL		GASTROINTESTINAL		PSYCHIATRIC
	Chills		Belly or abdominal pain		Anxiety
	Fever		Constipation		Insomnia
	Weight loss		Diarrhea		MUSCULOSKELETAL
	Fatigue		Blood in stool		Back pain
	HEENT		Nausea		Muscle Weakness/aches
	Ear drainage		Vomiting		Joint Stiffness/pain
	Hearing loss		GENITOURINARY		Arthritis
	Sinus pressure or infection		Painful urination/dysuria		Leg cramps
	Sore throat or hoarseness		Frequent urination/polyuria		HEMATOLOGIC
	Visual changes or loss of vision		Urinary Incontinence		Easy bruising
	RESPIRATORY		Foul smelling urination/UTI		Easy bleeding
	Cough		NEUROLOGICAL		OTHER
	Shortness of breath		Weakness		
	Sleep apnea or snoring		Headache		
	Asthma		Dizziness		
	Wheezing		Tingling/Numbness		
	CARDIOVASCULAR		Seizures		
	Chest pain		Tremor		
	Irregular heartbeat/palpitations		DERMATOLOGIC		
	Claudication		Rash		
	High blood pressure		ENDOCRINE		
	Syncope		Heat Intolerance		
	Dyspnea/ difficulty breathing		Cold Intolerance		