ATLANTA CARDIOLOGY ASSOCIATES LLC

Winston H. Gandy, Jr., M.D., F.A.C.C., F.A.S.E
11680 Great Oaks Way, Ste. 100
Alpharetta, GA 30022
Phone: (404)796-7011 Fax: (404)796-7099

ANNUAL PATIENT INFORMATION

First Name_____**M.I.**_____**Last Name** _____

Sex: ☐ **Male** ☐ **Female** **Date of Birth**_____/_____/_____

Marital Status: ☐ **M** ☐ **S** ☐ **W** ☐ **D**

Email:_____ **Patient Portal Access:** ☐ **Y** ☐ **N**

Mailing Address: _____

City_____ **State**_____ **Zip Code** _____

Home Phone_____ **Work** _____

Cell_____ **Preferred:** ☐ **Home** ☐ **Cell** ☐ **Work**

Primary Insurance _____ **Secondary Ins** _____

Primary Care Physician (PCP)_____ **Phone** _____

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** _____

ATLANTA CARDIOLOGY ASSOCIATES LLC

Winston H. Gandy, Jr., M.D., F.A.C.C., F.A.S.E
11680 Great Oaks Way, Ste. 100
Alpharetta, GA 30022
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 provideme 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 _____

ATLANTA CARDIOLOGY ASSOCIATES LLC

Winston H. Gandy, Jr., M.D., F.A.C.C., F.A.S.E
11680 Great Oaks Way, Ste. 100
Alpharetta, GA 30022
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	☐ Consultation Report	☐ ER Records	☐Office notes
☐ Operative Reports	☐ Discharge Summary	☐ Face sheet	☐ Echo, EKG, results
☐ Lab/Path Reports	☐ X-ray, MRI, CT Reports/Images	☐ ALL RECORDS	

☐Other _____

The above information may be released to:

☐ Winston H. Gandy, Jr., M.D., F.A.C.C., F.A.S.E
11680 Great Oaks Way, Ste. 100, Alpharetta, GA 30022
Phone: 404-796-7011
Fax: 404-796-7099

Records Retrieved 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

ATLANTA CARDIOLOGY ASSOCIATES LLC

Winston H. Gandy, Jr., M.D., F.A.C.C., F.A.S.E
11680 Great Oaks Way, Ste. 100
Alpharetta, GA 30022
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	_____	□ Yes	□ No
_____ Cell Phone	_____	□ Yes	□ No
_____ Text Messages	_____Same as cell phone _____	□ Yes	□ No
_____ Work Phone	_____	□ Yes	□ No
_____ Email	_____@_____	□ Yes	□ 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

ATLANTA CARDIOLOGY ASSOCIATES LLC

Winston H. Gandy, Jr., M.D., F.A.C.C., F.A.S.E
11680 Great Oaks Way, Ste. 100
Alpharetta, GA 30022
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: _____