NORTH ATLANTA CARDIOLOGY PC

2870 Ronald Reagan Blvd
Suite 200
Cumming, GA 30041

MICKY MISHRA, MD FACC

Phone: 404-994-4561
Fax: 404-994-4562

REGISTRATION INFORMATION

Name: _____ **Date of Birth:** _____

Address: _____ **Social Security No:** _____

_____

Phone Number (Cell): _____ **Home:** _____

EMAIL (Used only to allow patient login To Patient Portal): _____

Employment:

____Employed ____ Retired ____ Unemployed ____Married ____Single ____Divorced ____Life Partner

Employer: _____ Phone: _____

Circle one or fill in:

Primary Language: English – Spanish – Other _____

Ethnicity: Hispanic – Not Hispanic - Decline

Race: Caucasian – African American – Hispanic – Asian – Native Hawaiian or Other Pasific Islander – American Indian or Alaska Native - Other: _____

Emergency Contact Name: _____ **Relation:** _____

Emergency Contact Phone: _____

Primary Care Physician Name: _____ **Phone:** _____

Location Address: _____**Fax:** _____

Referring Physician: Name: _____ **Phone:** _____

Location Address_____ **Fax:** _____

Insurance Information:

Insurance Company: _____ Effective Date: _____

Name of Policy Holder: _____Policy Holder DOB: _____

Relation to Policy Holder: _____Policy Holder Employer Name: _____

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Secondary Insurance Company (if applicable): _____Effective Date: _____

Name of Policy Holder: _____Policy Holder DOB: _____

Relation to Policy Holder: _____Policy Holder Employer Name: _____

Pharmacy Information: As part of the Electronic Medical Record North Atlanta Cardiology uses the Surescripts Network to fill prescriptions electronically (e-prescribe).

Pharmacy Name: _____ Phone: _____

Location Address: _____

I consent to have messages regarding test results and appointment reminders left on a voicemail: (Initial)
_____Voicemail/Home #:_____
_____Voicemail/Cell #:_____

I do not consent to have messages regarding my test results or appointment reminders on any voicemail_____(Initial)

Do you have an Advanced Directive? (for informational purpose only)
____ Yes _____ No If yes, please provide a copy for your health record.
Check all that apply: _____ Living Will _____ Power of Attorney

Assignment of Benefits/Consent for Treatment:
I hereby assign all medical and/or surgical or testing benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges not paid by insurance and understand all referrals are my responsibility. I authorize this office to release all information necessary to secure payment. I voluntarily give consent for my medical treatment or my dependent's medical treatment to North Atlanta Cardiology, P.C. and authorize such treatment, examination, medications and diagnostic procedures including the use of radiographic studies, and lab, as ordered by my physician.

_____ _____
Patient Signature Date

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PATIENT MEDICAL HISTORY

Patient Name:_____ **DOB:**_____ **DATE**_____

Drug Allergies:_____

History of Heart Problems	Yes	No	When
Heart Attack	_____	_____	_____
Heart Murmur	_____	_____	_____
Rheumatic Fever	_____	_____	_____
Irregular Heart Rhythm	_____	_____	_____

Other Heart Problems:_____

_____

Other Medical Problems	Yes	No	When
Diabetes Mellitus	_____	_____	_____
High Blood Pressure	_____	_____	_____
High Cholesterol	_____	_____	_____
Stroke	_____	_____	_____
Stomach Ulcers	_____	_____	_____
Hiatal Hernia	_____	_____	_____
Thyroid Problems	_____	_____	_____
Asthma/Emphysema	_____	_____	_____
Cancer	_____	_____	_____

Other Medical Problems:_____

_____

Family History **(check all that apply)**	Yes	Family Member	No
Heart Attack	_____	_____	_____
Stroke	_____	_____	_____
High Blood Pressure	_____	_____	_____

Social History

Have you ever smoked?_____Do you still smoke?_____How much per day?_____

Do you drink alcohol?_____Do you still drink?_____How much?_____

Do you drink caffeinated beverages?_____

Do you exercise?_____How often?_____

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Medication List

Name	MG	Times taken daily

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FINANCIAL POLICY

We are all aware of the crisis to healthcare financing nationwide. Quality, personalized medical services may sometimes be expensive and we are working hard to contain costs on your behalf. There is much misunderstanding regarding the role of insurance and other "Third Party Payors" in the process. The following is an attempt to explain our policies in this regard:

1. Services are provided to patients, not to insurance companies. Private practice medicine is Fee-For-Service and implies a contract between patient and provider.
2. Insurance contracts are between companies and beneficiaries (patients) for reimbursement of certain covered expenses.
3. In cases where we do have contracts with managed care providers we will comply with your policy.
4. As a courtesy, we will file your claim(s) to the appropriate carrier. If we do not participate with your plan, payment is expected at the time of service. We accept Cash, Check, MasterCard, Visa, American Express and Discover.
5. All co-payments, deductible, co-insurance and balances are the patient's responsibility and payment are expected at the time of service.
6. Please bring your insurance card(s) with you on each visit.
7. In order for our business office to file your insurance correctly, it is your responsibility to give the receptionist a copy of your most current insurance card.
8. Certain insurance policies require you to have a Referral Number to see a Specialist. This will need to obtained from your Primary Care Physician in order to cover and pay your claims appropriately. If your referral has expired and you have not obtained a new referral, you will have to be rescheduled. It is your responsibility to provide the number at time of service or you will be liable for the charges in full.
9. Patients electing to be seen out of network will be responsible for payment at time of services.
10. Insurance coverage is determined by your contract with the company.
11. We will charge a No Show and Cancellation fee if no **contact with office staff** has been made to reschedule appointment within **24- business hour advanced notice.** Fees vary based on procedure.
12. In situations of severe financial hardship, this office will consider making special arrangements on a case-by-case basis. Please discuss this with our Practice Administrator at 404-994-4561 if you feel it applies to you.
13. We understand that some patients are not insured and have competitive Self Pay/Private Pay arrangements.
14. We are all here to serve and encourage you to communicate with our office should you have remaining questions, our staff is ready to help find the answers.

I hereby understand the financial policy of this office.

_____
Print Name

_____ _____
Signature Date

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PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and have been presented an opportunity to ask questions:

NAME: _____ Date of Birth: _____

Signature_____ Date: _____

For Office Use Only

On _____ at _____ North Atlanta Cardiology, P.C. staff made a good faith Attempt to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because of the following reason:

(check items that apply)

_____ Patient refused to sign

_____ Emergency prevented obtaining a receipt

_____ Other: _____
(describe)