**Atlanta Heart**
*Associates, P.C.*

| Date Received Form |
| --- |
| ______________ |
| (office use only) |

# FORMS COMPLETION

To better serve you, this questionnaire must be filled out in its entirety to have forms completed.

Patient Name: ______________________________ DOB: __________________

1) Indication for form (please specify Short Term Disability, Long Term Disability, Permanent Disability. If Medication Assistance, go to question #5. If FMLA, what is your relation ship to the patient?):

_______________________________________________________________

2) What dates, if any, were you out of work? ___________________________

_______________________________________________________________

3) Have you been released to return to work? ☐ Yes ☐ No ☐ Not Applicable

If so, what date? _____________ Restrictions:_______________________

4) Have you been hospitalized? ☐ Yes ☐ No If so, where? _______________

_______________________________________________________________

What diagnosis? ________________________________________________

5) When form is complete, please:

☐ Fax (fax number) ____________________________________________

☐ Mail (address) ______________________________________________

☐ Call for Pick Up (phone number)_________________________________

**By signing below, I acknowledge that it can take up to <u>5 to 7</u> business days for the completion of these forms and there is a <u>$10</u> charge per form to be completed.**

**▯ Note that if you want your forms faxed or mailed, you must pay the $10.00 charge in <u>ADVANCE</u> ▯**

Patient Signature: ________________________________ Date: __________________