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 7 to 10 business days for the completion of these forms and there is a $15 charge per form to be completed.

Note that if you want your forms faxed or mailed, you must pay the $15.00 charge in ADVANCE

Patient Signature: _____ Date: _____