Path Group of Atlanta, LLC
Psychiatry and Therapy Group

550 Pharr Rd NE, Suite 605
Atlanta, GA 30305
Office 404-235-5982 Fax 678-705-2756
www.pathgroupatl.com

CHILD / ADOLESCENT
PATIENT REGISTRATION INFORMATION
AND GUARANTOR AGREEMENT

Which Provider are you seeing today? Smitha Bhandari, MD Elana Zimand, PhD

Karla Viera-Negron, MD Jeremy Salzman, PsyD

PATIENT INFORMATION

Patient Full Name _____Nickname _____
(First) (MI) (Last)

Age _____ Date of Birth _____ Gender: Male Female

Street
Address_____

City/State/Zip_____

Cell Phone (parent/guardian) _____

Home/Work Phone (please circle one)_____Referred by_____

Pediatrician _____Phone Number_____

Pharmacy Name and Phone Number _____

Mother's Name and Contact Information:

_____
Print name email phone

Father's Name and Contact Information:

_____

Print name email phone

Patient Name _____ **Date** _____

School Name _____

School Address _____

School Phone _____

PATIENT MEDICATION HISTORY

Medication Allergies _____

Current Medications (name/dosage/frequency)

_____

_____

_____

GUARDIAN/FINANCIAL GUARANTOR INFORMATION

Print Name _____

(First) (MI) (Last)

Relationship to Patient_____

Street Address **(Leave Blank If Same As Patient)**

_____

City/State/Zip_____

Cell Phone _____

Home/Work Phone (please circle one)_____

Patient Name _____ Date _____

CUSTODY AGREEMENT

If the parents of the minor patient are divorced and custody is "Joint Legal," both parents need to sign the Consent for Treatment. However, if parents are divorced and only one parent signs the Consent for Treatment, *a copy of the custody agreement must be provided to PATH Group of Atlanta, LLC at the initial appointment*. This agreement must reflect which parent obtains authority over medical decision-making.

If divorced, second signature required,

Parent/Guardian/Guarantor Signature _____

Date _____

CONSENT FOR TREATMENT

I hereby agree to have my child be treated by physicians or mental health providers associated with PATH Group of Atlanta, LLC. I authorize PATH Group of Atlanta, LLC to provide information to any physician or therapist who referred me to PATH Group of Atlanta, LLC.

I, the undersigned, agree that I am financially responsible for all services provided by PATH Group of Atlanta, LLC. I am aware that office policy requires payments be made at time of service. I understand that unpaid balances over 30 days may incur a 3% late fee per month of the outstanding balance.

I have read the policies and understand and agree to them.

Parent/Guardian/Financial Guarantor Signature

_____

Print Name _____

Date _____