Path Group of Atlanta, LLC
Psychiatry and Therapy Group
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Atlanta, GA 30305
Office 404.235.5982 Fax 678.600.6566
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CHILD/ADOLESCENT
PATIENT REGISTRATION INFORMATION
AND GUARANTOR AGREEMENT

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

PATIENT INFORMATION

Patient Full Name _____ Nickname _____
(First) (Middle) (Last)

Age _____Date of Birth _____ Gender Male Female

Street Address _____

City/State/Zip/County _____

Primary Phone _____(cell/home)

Secondary Phone_____(cell/home)

SSN _____ Referred by _____

Pediatrician _____Phone number _____

Pharmacy Name/Phone Number _____

Father's Name and Contact Information:

_____

Mother's Name and Contact Information:

_____

School Name _____

School Address _____

School Phone _____

(Continued on reverse)

Patient Medication History

Medication Allergies_____

Current Medications (name/dosage/frequency)

GUARDIAN/GUARANTOR INFORMATION

Name_____ SSN _____
(First) (MI) (Last)

Relationship to Patient _____

Street Address _____

City/State/Zip_____

Primary Phone _____(cell/home)

Secondary Phone_____(cell/home)

Date of Birth _____ Gender M F Marital Status _____

Employer Name _____

Employer Address _____

Employer Phone _____

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.

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 to provide information to any physician or therapist who referred me to Path Group of Atlanta.

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/Guarantor Signature _____

Date _____

If divorced, second signature required,

Parent/Guardian/Guarantor Signature _____

Date _____