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
pathgroupatl.com

ADULT 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 Name _____ Age_____
(First) (Middle) (Last)

Date of Birth _____ Gender: M F Marital Status _____

Street Address _____

City/State/Zip _____

Cell Phone _____

Home/Work Phone (please circle one)_____

Email _____Referred by_____

Family Physician _____ Phone number_____

Pharmacy Name and Phone Number _____

Emergency Contact _____
(Name) (Phone)

(Relationship)

Employer Name _____

Employer Address _____

Employer Phone _____

(Continued on reverse)

Medication History

Medication Allergies_____

Current Medications (name/dosage/frequency):

_____

_____

_____

_____

FINANCIAL GUARANTOR INFORMATION (IF NOT PATIENT)

Guarantor Name _____
(First) (Middle) (Last)

Relationship to Patient _____

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

_____

City/State/Zip_____

Cell Phone _____

Home/Work Phone (please circle one) _____

CONSENT FOR TREATMENT

I hereby agree to 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.

Patient Signature _____ Date _____

Print Patient Name _____ Date _____

Financial Guarantor Signature _____ Date _____