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

Bonnie Wallace, LPC

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 _____

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OFFICE POLICIES

OFFICE HOURS AND EMERGENCY INFORMATION

Office hours are Monday through Friday, 9 am to 5 pm. If you have a medical emergency, please call 911 or go to your local emergency room. If you have an urgent question after normal business hours, please call Dr. Bhandari at 404-917-3256. Otherwise, all routine calls will be answered by the following business day.

PAYMENT POLICY

All patients are required to pay the session fee in full at the time services are rendered. We accept checks, cash and credit cards. We kindly request that you provide your credit card at each visit.

APPOINTMENT CHANGES/CANCELLATIONS

Your appointment times are reserved and if you cancel an appointment with less than 24 hours notice, you will be charged the full fee. After hours, you may leave notice of cancellation on our voicemail service. If for any reason the doctor must cancel an appointment with you, all efforts will be made to notify you as soon as possible.

OFFICE PHONE POLICY

Please be aware that our doctors are meeting with patients throughout the day and may not be able to return your phone call until a later time. When leaving a message for your doctor, please leave both daytime and evening telephone numbers. Please note that this is for brief phone calls only and you must schedule a phone appointment for extensive calls.

EXTENSIVE PHONE CALL POLICY

For longer phone calls, you may call the office and schedule a phone appointment with your doctor. There will be a routine charge for phone appointments based on the length of call. Please

note that there may be an additional charge for after hour calls, except for life threatening emergencies.

Fees for Extensive Phone Calls (charges may vary with each doctor)
15 - 30 minutes $50

MEDICAL INSURANCE POLICY

Our providers do not contract with any insurance companies. However, if your insurance company provides out of network benefits, you may file your own claims for reimbursement. *We must inform Medicare, Tri-Care and Medicaid patients that we have opted out of these plans. Therefore, patients with the insurance coverages stated above are not permitted to submit claims from our practice to these insurance providers for reimbursement.*

MEDICATION REFILL POLICY

We make every effort during your appointment to provide enough medication to reach your next appointment. However, we are aware that emergencies may arise and appointments may have to be rescheduled for a later date. Medications refills may be requested during regular office hours by calling the office. We will complete medication requests within 24-48 hours from the time of the request. If requesting a stimulant (controlled medication), please call the office for more information. Stimulant medications require a prescription in hand which may be picked up at the office or mailed to your address. There may be a charge of $10-$25 for a refill.

Prescriptions may only be called in for current patients who maintain their regularly scheduled appointments. We encourage patients to pay close attention to your medication supply to ensure that we have enough time to complete each medication request.

REQUEST FOR FORMS OR LETTERS POLICY

Any requests for forms to be completed or letters to be written on your behalf are subject to a $25 to $50 preparation fee.

TERMINATION OF TREATMENT

You are under no obligation to continue services and may opt to terminate treatment. Should you decide to discontinue treatment, we strongly urge you to notify the doctor of your decision so that it may be discussed openly.

FINANCIAL GUARANTOR AGREEMENT

This agreement will remain in effect until written notice of alternate payment arrangements are provided to PATH Group of Atlanta, LLC. The current Guarantor is responsible for any and all charges incurred prior to receipt of notification of other arrangements. If you wish to change Guarantors, please have the newly appointed Guarantor complete a separate Guarantor Agreement with PATH Group of Atlanta, LLC.

PLEASE RETAIN THIS PAGE FOR YOUR RECORDS AND RETURN THE SIGNATURE PAGE TO THE OFFICE.

PATIENT NAME _____

NOTICE OF PRIVACY POLICIES

I acknowledge that I have read and agreed to, and was offered a copy of the Notice of Privacy Practices for the PATH Group of Atlanta, LLC.

If you would like to take home a copy of our Notice of Privacy Practices, please check here: ☐

I hereby acknowledge that I have read and agree to the office policies of PATH Group of Atlanta, LLC.

Patient Signature ***(Parent if patient is a minor)*** _____ Date _____

Print Name _____

Financial Guarantor Signature _____ Date _____

Financial Guarantor Name (please print) _____

PLEASE RETURN THIS PAGE TO THE OFFICE AND RETAIN THE OFFICE POLICIES PAGE FOR YOUR RECORDS.