



**PATIENT REGISTRATION INFORMATION
AND GUARANTOR AGREEMENT**

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

PATIENT INFORMATION

Patient Name _____ Age _____
(First) (Middle) (Last)

Street Address _____

City/State/Zip/County _____

Primary Phone _____ (cell/home)

Secondary Phone _____ (cell/home)

Date of Birth _____ Gender M F Marital Status _____

SSN _____ Referred by _____

Family Physician _____ Phone number _____

Pharmacy Name/Phone Number _____

Emergency Contact _____
Name /Phone/Relationship

Employer Name _____

Employer Address _____

Employer Phone _____

Medication History

Medication Allergies _____

Current Medications (name/dosage/frequency)

GUARANTOR INFORMATION

Guarantor Name _____ SSN _____
(First) (Middle) (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 _____

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 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.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____