



**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 \_\_\_\_\_

**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 \_\_\_\_\_