Path Group of Atlanta, LLC
Psychiatry and Therapy Group
550 Pharr Rd NE, Suite 305
Atlanta, GA 30305
Office 404.235.5982 Fax 678.600.6566
pathgroupatl.com

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 _____

(Continued on reverse)

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 _____