GA PSYCHIATRIC SERVICES, LLC

2150 Peachford Road, Suite K, Atlanta, GA 30338

PATIENT INFORMATION		
Last Name	First	Middle
Birth Date	Gender: ☐ Male ☐ Female	Social Security #:
Address		
City	State	Zip
Home Phone #		Work Phone #
Cell #		E-mail
Employment Status: ☐ Employed	☐ Unemployed	☐ Disabled ☐ Student
School and/or Employer:		Grade:
(*Optional)		
Ethnicity*	Religion*	Marital Status*

BILLING INFORMATION: **Insurance** **Selfpay**		
Policy Holder (Insured/Guarantor) Information		
Last Name	First	Middle
Birth Date		**Gender:** ☐ Male ☐ Female
Address		
City	State	Zip
Phone #		
Employer		
Primary Insurance Company Name		
Member ID / Policy #		Group #
Copay ($)	Coinsurance (%)	Deductible ($)
Billing correspondance should be mailed to (check one) ☐ *Patient*	☐ *Policy Holder*	☐ *Other (see below)*
Last Name	First	Middle
Address		

OTHER CONTACT INFORMATION (if applicable)	
Emergency Contact:	**Ph:**
Family Contacts : Biological Parent(s) / Adopted Parent(s) / Foster Parent(s) / Guardian(s) / Case worker	
Parent #1	Parent #2

I hereby authorize GA Psychiatric Services, LLC to release necessary information to insurance carriers for reimbursement. I understand that I am responsible for any unreimbursed balance. I understand privacy practices of GA Psychiatric Services, LLC as required by HIPAA laws. I was given opportunity to review privacy practices and policies of the clinic. I consent for treatment by Suneel Katragadda M.D. or other mental health providers working with GA Psychiatric Services, LLC.

PATIENT / GUARDIAN SIGNATURE _____ Date _____