GA Psychiatric Services, LLC

2150 Peachford Road, Suite K
Atlanta, GA 30338
770-458-0450   770-458-0470 (fax)
www.gapsychiatry.com

PATIENT INFORMATION				
Last Name	First		Middle	
Birth Date			**Gender:**	Male / Female
Social Security #				
Address		City, State, Zip code		
Home Phone #		Work Phone #		
Cell #		E-mail		
Employment Status:	Employed	Unemployed	Disabled	Full-time / Part-time student
School / Employer		Grade		
(*Optional) Ethnicity*	Religion*		Marital Status*	
CURRENT/ACTIVE INSURANCE INFORMATION				
Person responsible for the bill (Insured/Guarantor) :				
Last Name	First		Middle	
Birth Date			**Gender:**	Male / Female
Address				
City, State, Zip Code				
Phone #				
Employer				
Primary Insurance Company Name				
Member ID / Policy #			Group # / Account #	
Copay ($)		Coinsurance (%)	Deductible ($)	
OTHER CONTACT INFORMATION (if applicable)				
Emergency Contact:	Name:		Ph:	
FAMILY CONTACTS (Circle one if applicable) 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 ________________________