BEHAVIORAL MEDICINE INSTITUTE OF ATLANTA
PRE-REGISTRATION

PATIENT: (Please Print) ____ **DATE:** ________________

ADDRESS: ____ CITY: _______________________________
STATE & ZIP: ___________________________ BIRTH DATE: ______________ SEX: _________ RACE: _____________
MARITAL STATUS: ______________________ SOCIAL SECURITY: ____

HOME PHONE: ________________________ **CELL:** ______________________ **WORK:** _______________________

WHICH IS PREFERRED CONTACT NUMBER? ______________ **MAY WE LEAVE A MESSAGE? YES NO**

EMPLOYER: ____
ADDRESS: ____ CITY: _______________________________
STATE & ZIP: _______________________________________ OCCUPATION: ____________________________________

SPOUSE: ____
HOME PHONE: ____________________________ CELL: _______________________ WORK: _______________________
ADDRESS: _______________________________ CITY: ____________________STATE & ZIP: ___________________
EMPLOYER: _____________________________________ ADDRESS: ____
CITY: ____ STATE & ZIP: ________________________________

IF PATIENT IS A MINOR:

PARENT/GUARDIAN NAME: ____
RELATIONSHIP TO PATIENT: ______________________ ADDRESS: ____
CITY: ____ STATE & ZIP: __________________________________
HOME PHONE: ____________________________ WORK: ______________________ CELL: _____________________
SOCIAL SECURITY: ___________________________ EMPLOYER: ____
BUSINESS ADDRESS: ____ CITY: __________________________________
STATE & ZIP: ____

NEAREST RELATIVE NOT LIVING WITH PATIENT:

NAME: ____ RELATIONSHIP: ___________________
ADDRESS: ___________________________________ CITY: _______________________ STATE & ZIP: _______________
HOME PHONE: ______________________________________ BUSINESS PHONE: _______________________________

REFERRED BY:

Source	**Address/phone number**

Physician: ____
Psychologist: ____
Attorney: ____
Judge: ____
Caseworker: ____
Parole officer: ____
Other agency: ____

How will you be paying?

Cash Check Credit card (MC/Visa/AM Ex/Discover)

PLEASE COMPLETE OTHER SIDE

BEHAVIORAL MEDICINE INSTITUTE OF ATLANTA

Consent for Purposes of Treatment, Payment, and Healthcare Operations

---

I consent to the use or disclosure of my Protected Health Information by Behavioral Medicine Institute of Atlanta (BMI) for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills, or to conduct healthcare operations of BMI. I understand that diagnosis or treatment of me by the clinicians at BMI may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. BMI is not required to agree to the restrictions that I may request. However, if BMI agrees to a restriction that I request, the restriction is binding on BMI and doctors and therapists who work for BMI.

I have the right to revoke this consent in writing, at any time, except to the extent that BMI has taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information collected from me and created or received by my physician, another healthcare provider, a health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review BMI's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of BMI. The Notice of Privacy Practices for BMI is also provided at the registration window or at the website, www.bmiatlanta.com. This notice of Privacy Practices also describes my rights and BMI's duties with respect to my protected health information.

BMI reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing BMI's website, calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative (printed)

Description of Personal Representative's Authority

Date