

**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: _____

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