ATLANTA BEHAVIORAL MEDICINE, INC

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Mohammad Ahmad, M.D. Rukhsana Ahmad, M.D.

REGISTRATION FORM

(Please Print - ALL INFORMATION MUST BE COMPLETED)

Today's Date ___________________

PATIENT INFORMATION

Patient's Last Name	First		Middle		Mr / Mrs Ms / Miss		Marital Status (Circle One) Single / Mar / Div / Sep / Wid/ Child
Is this your legal Name?	If not, what is your legal name?		Maiden Name		DOB	Age	Sex: MALE / FEMALE
Home Address	City	State	ZIP Code		Social Security #		Home Phone
Mail Address	City	State	ZIP Code		Work Phone		Cell Phone
Occupation	Employer/School		Employer/School Address, City, State, ZIP Code				
Primary Care Physician	Physician Phone	Physician Fax	Physician Address				

Condition Due to an Accident? YES / NO Referral Party:

Other Family Members a Patient of this office? YES / NO If Yes, please provide Patient Name:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Payment	Date of Birth	Mailing Address (if different)		Home Phone
Is this person a patient here? YES / NO			Work Phone	Cell Phone
Occupation	Employer	Employer Address, City, State, ZIP Code		

Is this patient covered by insurance? YES / NO

Please indicate primary insurance ___ Medicare ___ Medicaid ____ Blue Cross/Blue Shield ____ Humana ____ Aetna

____ Magellan BH ____ Other ___________________________

Subscriber's Name	Subscriber's S.S. #	Birth Date	Group #	Policy #	Co-Payment

Patient's Relationship to Subscriber ____ Self ____ Spouse ____ Child ____ Other ____________________________

Name of Secondary Insurance (if applicable) Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ____ Self ____ Spouse ____ Child ____ Other ____________________________

IN CASE OF EMERGENCY

Name of Nearest Living Relative NOT Living with you	Relationship to Patient	Home Phone	Work Phone

The above Information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. As a courtesy to me, the Patient, Atlanta Behavioral Medicine, Inc.(Dr. Mohammad and/or Rukhsana Ahmad, M.D.) will file insurance claims on my behalf and I understand that I am financially responsible for all charges and balances due to Atlanta Behavioral Medicine, Inc.(Dr. Mohammad and/or Rukhsana Ahmad, M.D.) in any case where my insurance does not pay or cover for the services provided by Atlanta Behavioral Medicine, Inc.(Dr. Mohammad and/or Rukhsana Ahmad, M.D.). I also authorize Atlanta Behavioral Medicine, Inc.(Dr. Mohammad and/or Rukhsana Ahmad, M.D.) or insurance company to release any information required to process my claims.

X ____

PATIENT/GUARDIAN SIGNATURE DATE

Atlanta Behavioral Medicine, Inc

Name of child ______________________________ Age ________ Sex ________ Date _______________

1: Presenting Problems: (Circle all that apply)

Very unhappy Irritable — Temper outbursts — Withdrawn — Day dreaming — Fearful — Clumsy
Overactive — Slow Short attention span — Distractible — Lacks initiative — Undependable
Peer conflict — Phobic — Impulsive — Stubborn — Disobedient — Infantile — Mean to others
Destructive — Trouble with the law — Running away — Self-mutilating — Head banging
Rocking — Shy — Strange behavior — Strange thoughts — Fire setting — Stealing
Lying — Sexual trouble — School performance — Truancy — Bed wetting — Soiled pants
Eating problems — Sleeping problems — Sickly — Drugs use — Alcohol use — Suicide talk

Other (Please use the back page with Q# for extra space)

____

How long have these problems occurred? (number of weeks, months, years) ______________________

Problems perceived to be; ______ very serious — ______ serious — ______ not serious

What changes would you like to see in your child? ____

What changes would you like to see in your family? _______________________________________

2: Past Hx: (Previous hx psychiatric, emotional, or behavioral problems and treatment, previous medications, any medication reactions, any medications which was helpful: (use the back page with Q# for extra space)

3: Family Hx: (List the relationship and the nature of psychiatric, emotional, behavioral problems, drugs, alcohol or other similar issues in any of your immediate family member: use the back page with Q# for extra space)

4: Medical Hx: (Please list all the medical problems, list any medications you are taking and any medication allergies. Any head injuries, seizures, and loss of consciousness, any pain management issues: Please use the back page with Q# for extra space)

5: Developmental Hx: (Describe any deficit and delays in sitting, standing, walking, talking)

(Circle all that apply) Relationship to siblings and peer: individual play — group play — competitive cooperative — leadership role — a follower. Describe special habits, fears, or idiosyncrasies of the child:

____

6: Educational Hx: Did child have any specific learning difficulties? _____ Yes _____ No. Does child appear motivated for school? _____ Yes _____ No. Has child ever been suspended or expelled? _____ Yes _____ No.

Completed By ____________________________ Relationship ____________________ Date ____________

Atlanta Behavioral Medicine, Inc

AGREEMENT

I hereby authorize **Atlanta Behavioral Medicine Inc.** to provide me ______________________________

(Your Name)

And or my following dependent(s) ____

(Your Dependent or Child's Name)

Psycho-diagnosis, psychiatry, psychotherapy and such other psychological services as are required. I understand that I may withdraw my consent for any specific treatment at any time. I understand that there is no assurance that I will feel better and that in the course of assessment and /or therapy material may be discussed which could be upsetting and that this may be necessary to help me resolve my concerns.

CONFIDENTIALITY

I further understand that information about my treatment may not be disclosed except for the following reasons:

a. If I signed a waiver requesting release of information
b. If a court orders the release of my records
c. If I raise my mental status or competency in a legal proceedings
d. If there is reason to believe that there clear and immediate probability that would seriously harm myself or others
e. If there is evidence or strong suspicion of child or elder abuse

FEES

I understand that fees are payable at the time of each treatment session. I also understand that if any associates of ABM, Inc. accept assignments of insurance benefits, my signature below acts as one on file for billing purposes. I authorize the release of any payment, medical, psychiatric, and counseling information necessary to process mine or my family member's claims and related claims. I hereby authorize payment directly to Atlanta Behavioral Medicine Inc. (Mohammad and Rukhsana Ahmad, MD) or any of the associates of the insurance benefits otherwise payable to my family or me for the professional services rendered, I understand I am financially responsible to the Atlanta Behavioral Medicine Inc. (Mohammad and Rukhsana Ahmad, MD) for all charges not covered by this agreement.

RELEASE OF INFORMATION

I hereby Atlanta Behavioral Medicine Inc. (Mohammad and Rukhsana Ahmad, MD) to release and obtain information from other professionals who might have provided services for me. I understand that the nature, of this communication is solely for the purpose of continuity of my care. This is only to- Verify therapeutic modalities and their efficacy rather than disclosure of specific issues during the therapy process.

RESPONSIBLE PARTY ____ DATE ______________

TREATMENT PROVIDER/WITNESS ______________________________ DATE ______________

Atlanta Behavioral Medicine, Inc

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand my health information is private and confidential. ABM INC will make continuing effort to protect the privacy and confidentiality of my personal health information.

I understand that ABM may use and disclose my personal health information to provide mental health care, to handle billing and payment, ant to take care of other mental health care operations. [There will be no other disclosures of this information unless I specifically authorize it. I understand that rarely the law may require the release of my information without my authorization.]

ABM has a detailed policy called the "Notice of Privacy Practices." It contains information about protecting my privacy. This "Notice of Privacy Practices" may be updated as needed and a copy will be available upon request. I will assist ABM by following office procedures (written request, reasonable time for completion and copying and paying the charges where indicated) if I choose to exercise any of my rights described in the "Notice of Privacy Practices." These rights include access, authorization for release of information, record of disclosures, and communication by the available method of my choice.

My signature below indicates that I have read and understand a current copy of ABM INC "Notice of Privacy Practices."

____ ________________

Patient or Legally Authorized Signature Date of Birth

____ ________________

Relationship to Patient (if Applicable) Date

Atlanta Behavioral Medicine, Inc

Following are the charges which might not be covered by your insurance

PAYMENT IN FULL OR C0-PAY IS REQUIRED AT THE TIME OF SERVICE

Cancellation without 24 hours notice	$30.00
Appointment No-Show	$30.00
FMLA	$50.00
Other Paperwork and letters	$50.00 - $250.00
Returned Checks	Bank Charges Plus $25.00
Hospital / Home Bound	$30.00

24 hours notice is required for any cancelled appointments. If the appointment is not cancelled there will be a $30.00 charge for missed appointments.

We file insurance for your convenience. Please update your insurance information immediately if there is a change in coverage.

Bills are sent each month and are due upon receipt. If you are unable to make payment in full, please call our billing office at 770-458-1594 to make payment arrangements. We will send any returned checks not paid within 30 days and any other unpaid charges after 60 days to collection.

We appreciate your continued association with Atlanta Behavioral Medicine, Inc. Please sign below acknowledging the receipt of a copy of this notice.

Patient or Responsible Party Name ____

Signed ____ Date ________________