

4536 Barclay Drive,
Atlanta, GA 30338

Phone: (770) 458-8711
Fax: (770) 458-8640

IMPORTANT INFORMATION

Dear Patient,

It is very important that you download the Market Insurance Packet in addition to this packet. Please fill out both packets as completely as possible. This will ensure that your insurance claims are filed correctly and timely. Please bring both completed packets to your first appointment.

If you have any questions, please call the Front Desk at (770) 458-8711 x0

Sincerely,

The Front Office Staff
Atlanta Center for Eating Disorders



Atlanta Center for Eating Disorders is CARF-accredited for
Day Treatment: Mental Health (Adults) and Day Treatment: Mental Health (Children and Adolescents)

Atlanta Center for Eating Disorders
Patient Registration Information

Patient Name: _____ Date: _____

Current Address: _____

City: _____ State: _____ Zip: _____

Phone# Home (____) _____ Work (____) _____ Cell (____) _____

May we leave you a message at home? _____ at work? _____ on cell? _____

Date of birth: _____ - _____ - _____ Age: _____ SS# _____ Gender: (F) (M)

Employed () Unemployed () Full-time Student () Part-time Student ()

Referred to ACE by? _____

May we thank this person for referring you? Yes No Phone# _____

If patient is under 25 years of age, please provide information for reaching each parent.

Mother's Name: _____ Cell phone: _____ Evening phone: _____

Father's Name: _____ Cell phone: _____ Evening phone: _____

Responsible Party Self Parent* Spouse Other

(please fill out completely, even if same as above)

Name: _____ SS# _____ D.O.B. _____ - _____ - _____

Permanent Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer: _____

Insurance Information:

Primary Insurance: _____ Phone: _____

Insured's Name: _____ SS# _____ DOB: _____

ID# _____ Group# _____

Assignment of Benefits, Financial Agreement and Consent to Communicate with Financially Responsible Party

I hereby give lifetime authorization for payment of insurance benefits to be made directly to the Atlanta Center for Eating Disorders and any assisting practitioners, for services rendered at the Atlanta Center for Eating Disorders. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event that I default on payment of my bill, I agree to pay all costs of payment collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I understand that this may include information from my chart. I further agree that a photocopy of this agreement shall be as valid as the original. I further authorize the Atlanta Center for Eating Disorders to communicate with the Financially Responsible Party named above regarding any billing issues.

Date: _____ Patient Signature: _____

Date: _____ Responsible Party Signature: _____

Atlanta Center for Eating Disorders

Patient Emergency Medical Treatment Form

It is important to us that your health and safety is maintained at all times you or your child or loved one is here at ACE. Should a medical emergency occur during treatment at ACE, and in order to help you, your child or loved one access appropriate emergency medical services, please complete the information below so that there is no delay in responding to an emergency. **This form is a required part of your clinical paperwork and allows us to remain compliant with CARF policies.**

Date: _____ **Patient's Full/Legal Name:** _____

Date of Birth: _____ **SS or License/ID #:** _____

Home Address: _____

Home Phone: _____ **Cell Phone:** _____

Significant medical problems AND HOW STAFF SHOULD REACT (eg. in case of seizure, use of Epi Pen or other responses to allergic reactions, etc):

Name, address and phone number(s) of physician(s) to be called in the event of an emergency

Name(s) and type of physician: _____

Address: _____

Phone number: _____

Other information about contacting this physician: _____

Name, address and telephone number of a relative or other person to notify:

Name(s) and relationship: _____

Phone numbers to call in order of preference: _____

Address: _____

Insurance Information:

Medical Insurance Company: _____

Policy number: _____ Group number: _____

Please provide any information ACE staff or medical professionals would need to know in the event of an emergency:

Medication allergies: _____

Current medications (prescription and over the counter, including names, strength, how and why they are taken):

Hospital preference, if any: _____

Please note any other pertinent information on the back side of this form.

Atlanta Center for Eating Disorders
4536 Barclay Drive, Suite A
Atlanta, GA 30338

Billing Procedures

- We file insurance to your primary insurance company as a courtesy to you. If you have a secondary insurance company, it will be your responsibility to file with them. You are responsible for your bill regardless of the amount that insurance pays and you are ultimately responsible for following up with your insurance company if ACE has difficulty collecting payments. You also may choose to file your own claims.
- Some insurance companies only reimburse certain procedures or providers (i.e., may not pay for nutrition counseling or unkept appointments). If we know of limitations set by your insurance company, we will not submit claims for these particular program components. Nevertheless, you will be responsible for these charges. If your account has not been paid for more than 60 days and a payment plan has not been agreed on, ACE has the option of using legal means to secure payment.

ATTENDANCE:

- Missed sessions with less than 24 hours notice will be billed as a late cancellation or unkept appointment. Insurance companies will not pay for unkept appointments, therefore you are responsible for the full fees. We will send you a statement at the time of a missed appointment. Payment is expected for missed appointments in addition to any other payment arrangements. No scholarship or patient courtesy discounts will be given for missed appointments. However, charges for an absence may be reversed if you and your case manager decide that the absence was an unforeseeable emergency.

I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event that I default on payment of my bill, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I understand that this may include information from my chart. I further agree that a photocopy of this agreement shall be as valid as the original. I give ACE my consent to release public health information requested by my insurance company for payment

Patient Signature

Date

Witness

Date

Financially Responsible Party

Date

Relationship to Patient

Atlanta Center for Eating Disorders
Initial Information

Name: _____ Date: _____

In your own words, please briefly explain why you are seeking treatment at this time.

If you are here primarily because someone else has encouraged you to be here, please briefly state what you think their concerns and goals are for you.

Give a brief history of your problems: first symptoms, severity, periods of relief.

Do you have any other symptoms or related problems? (anxiety, depression, obsessions, compulsions, relationship problems, etc.)

Have you had any previous therapy or treatment? Describe briefly, including what was most and least helpful.

Please describe your relationship with the following people (past and present):

Mother:

Past: _____

Present: _____

Father:

Past: _____

Present: _____

Sister(s):

Past: _____

Present: _____

Brother(s):

Past: _____

Present: _____

Is there any family history of emotional problems, addictions, or major physical problems? Please describe:

Have you experienced any traumatic events, past or present? (deaths, accidents, loss, abuse).

With whom do you live? _____
How are your relationships with the persons living with you? _____

On a scale of 1-10, how would you rate the current quality of your life? (circle #)

10 9 8 7 6 5 4 3 2 1 0
excellent very good good Fair not so good poor miserable

Please list the number and names of any children you have had or raised.

How would you describe the quality of the relationships with these children?

What is your marital history and how would you describe the quality of this (these) relationship(s).

Describe your leisure time (what you do with free time, hobbies, how much time spent in leisure)

How would you describe your sexual preference? _____

Are you experiencing any problems in this area? _____

Are you experiencing any occupational difficulties? _____

What is your current eating pattern?

Good Day _____

Bad Day _____

Do you have a spiritual/religious background? _____
What is your current involvement? _____

Do you want to use your spiritual/religious faith as part of your recovery process?

Cultural Background: (race, ethnicity, family traditions) _____

Are there any cultural practices linked to your racial/ethnic background that are important to you and that might impact your treatment/recovery?

Please describe the goals you hope to achieve through treatment (stopping symptoms, learning skills, decreasing perfectionism, etc.).

Do you already have preferences related to treatment (level of care, days available, types of groups, etc)?

Please indicate what you see as strengths or abilities that you have which may help you in your recovery process (personality traits, motivation, spirituality, friends and family support, social skills, work skills, talents or hobbies, etc)

