

Atlanta Center for Eating Disorders
Patient Registration Information

Patient Name: _____ Date: _____

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

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

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: _____

* - If divorce/custody decree states that both parents are financially responsible, please have both parents fill out separate forms and sign next to Responsible Party Signature.