REGISTRATION

Last Name____________________________First_______________________MI___________

Address____

Date of Birth______________ Last 4 digits of SS______________________________

Best phone number to reach you: ____________________email:________________________

May leave message? Y / N Occupation _______________________

If a minor or dependent:

Guardian Name__________________________________ Phone #______________________

Who referred you?____

Allergies to medications: ____

EMERGENCY CONTACT

Name____Phone#______________________

INSURANCE INFORMATION

Your Insurance Provider ____

You may file with your insurance for reimbursement. We do not provide billing services.

Dr. Giorgadze does NOT participate in the Medicare Program. If you are a patient who has Medicare coverage but wish to consent to treatment in this office, please sign and date below.

Signature of Medicare Insured Declining___________________________ Date___________

PAYMENT POLICY

All payment is due at the time service is rendered. If you plan on filing with an insurance carrier for payment reimbursement, you may use your office receipt. Some of the services including

Ketamine infusion therapy may not be covered by insurance. You are responsible for the balance not covered by insurance.

Ketamine treatment 1 hour - $350 Initial Consulatiton - $120 Follow-up Consultaion - $50-100

Follow-up consultation are only provided to patients in ketamine therapy. If ketamine therapy is terminated, your psychiatric care should be transferred to a regular psychiatrist.

APPOINTMENT CHANGES/CANCELLATIONS

Patients are charged $75 for a missed ketamine appointment, $25 for a missed regular appointment unless a 48-hour notice is given. Please know that most insurance carriers will not reimburse for missed appointments.

OFFICE HOURS

Office hours are by appointment Monday through Friday, 9:00AM through 5:00PM and some Saturdays 9:00 AM through 2:00 PM.

EMERGENCIES & PHONE / EMAIL POLICY

Should you wish to contact Dr. Giorgadze, please call at 678-701-7725. You may leave a message on voicemail, and all urgent calls will be returned within 24 business hours. Please, do not use e-mail to discuss confidential medical issues or to notify of medical emergencies. Appointments could be requested / changed via e-mail. Should you experience a life threatening emergency, you are encouraged to call 911 for assistance. You are then encouraged to notify Dr. Giorgadze. Every effort will be made to return your call promptly.

Non-urgent calls made after business hours will be returned as quickly as possible.

CONSENT TO TREATMENT & GUARANTOR RESPONSIBILITY

I have read the policies listed, and I understand and agree with them. I hereby agree to be interviewed, have records collected and treated by Andro Giorgadze, MD, and when necessary, other physicians covering in his absence. I authorize Dr. Giorgadze to communicate and provide information concerning my treatment to a physician or therapist who referred me to his practice. I agree that I am responsible for all charges for services rendered.

PATIENT SIGNATURE____ DATE______________

GUARDIAN (IF APPLICABLE)__________________________________ DATE_____________

Please, list all current medications (do not include past medications)

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Please, list all serious medical (not psychiatric) problems in the past and currently

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Please, check all that apply

- ☐ serious heart issues
- ☐ serious lung issues
- ☐ untreated sleep apnea
- ☐ untreated high blood pressure
- ☐ history of seizures
- ☐ history of manic episodes
- ☐ regular use of alcohol
- ☐ regular use of opiates
- ☐ regular use of recreational drugs- including THC
- ☐ tendency to get nausea with medictaions
- ☐ frequent panic attacks
- ☐ taking high dose of benzodiazepines- e.g Xanax, Klonopin, Ativan, Valium etc