

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 Consultation - \$120 Follow-up Consultation - \$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)

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

Please, check all that apply

- | | |
|--|---|
| <input type="checkbox"/> serious heart issues | <input type="checkbox"/> regular use of alcohol |
| <input type="checkbox"/> serious lung issues | <input type="checkbox"/> regular use of opiates |
| <input type="checkbox"/> untreated sleep apnea | <input type="checkbox"/> regular use of recreational drugs- including THC |
| <input type="checkbox"/> untreated high blood pressure | <input type="checkbox"/> tendency to get nausea with medications |
| <input type="checkbox"/> history of seizures | <input type="checkbox"/> frequent panic attacks |
| <input type="checkbox"/> history of manic episodes | <input type="checkbox"/> taking high dose of benzodiazepines- e.g Xanax, Klonopin, Ativan, Valium etc |