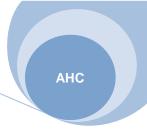
Atlanta Healing Center



Demographics/Financial Agreement

Patient:	SSN:	DOB:	
Patient Address:			
	State: Zip:		
Phone:	Cell Phone:		
Email:			
Appointment Reminders: ☐ Text	□ Email □ Phone		
Marital Status: ☐ Single ☐ Mar	ried □ Divorced □ Separated	Gender:	
Race/Ethnicity:			
African American Pacific Islander	_Asian Caucasian Hispar _ Other	nic Native American	
Employer:	Employe	er Phone:	
School:	School Phone:		
Primary Care Physician:			
Address:			
MD Phone:			
Were you referred to AHC?	If so, by whom:		
Legal Status: ☐ Probation ☐ Pa	arole □ Pre-trial □ No current legal invo	lvement	
Legal History (specify charges):			
Insurance Company:	Subscriber DOR:		
Policy Number:			
Subscriber Name:			
	of an emergency I consent that an AHC sta		
Name:	Relationship:		
Phone:	Address:		
returned by the bank for NSF or a payments will be added to the ori	e by check or credit card. A \$40.00 fee will any other reason. Any costs incurred in the ginal charges in addition to a \$25.00 admir 6 monthly for debt over 30 days late.	e collections of delinquent	
Patient Signature	Da	ate:	
Staff Signature:		ate:	
Demographics Form	/Financial Agreement		

"This information has been disclosed to you from records whose confidentiality is protected by State: Section 5328, Welfare and Institutions Code; and/or Federal Law. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose."