Noel T. Rivers-Bulkeley, M.D.

ATLANTA PRIVATE PSYCHIATRY

PATIENT REGISTRATION

(PLEASE PRINT)

PATIENT INFORMATION

Last Name	First Name	M.I.	Relationship Status (Circle One) Sgl / Committed / Mar / Sep / Div / Wid
Sex ☐ Male ☐ Female	Date of Birth mm/dd/yy		Social Security Number
Street Address	Apt. No.	City	State / Zip Code
Home Telephone ( )	Work Telephone ( )		Mobile Telephone ( )
Employer or School Attended	Referred By		

EMERGENCY CONTACT

Name a Local Friend or Relative	Relationship to Patient
Address	Telephone ( )

FINANCIAL RESPONSIBILITY

Last Name	First Name	M.I.	Relationship to Patient
Address			Telephone ( )

PLEASE READ THE FOLLOWING CAREFULLY:

- *I consent to treatment for the above named patient.*
- *I accept full financial responsibility for services rendered by Noel Rivers-Bulkeley, M.D. and I understand that the payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.*
- *I understand that Noel Rivers-Bulkeley, M.D. is a non-participating provider (a physician not affiliated with a commercial insurance carrier or managed care plan). I acknowledge that it is my responsibility to contact the insurance company in order to determine my out-of-network benefits and, if required, obtain precertification prior to seeing the doctor.*
- *I understand that if I choose to file claims for reimbursement with my insurance company, it is my responsibility to obtain, complete and submit the required forms (Dr. Rivers-Bulkeley will provide a properly coded receipt for my payments).*
- *I agree to pay for any appointments which I miss or fail to cancel at least 24 hours in advance, except in case of an emergency.*

PATIENT / GUARDIAN SIGNATURE DATE