Adult Registration **Avery Psychological Services** Authorization # __________

Patient Name: ________________________________ DOB: __________ Age:______ Female □ Male □

Street Address: ________________________________ SS#: ________________________________

City, State, Zip: ____

Cell Phone: ________________________________ Home Phone: ________________________________

Emergency Contact: ________________________________ Town ____________ Phone: ________________

Relationship : ________________________________ Work Phone: ________________________________

Physician: ________________________________ Town __________ MD Phone: ________________

Employed (please circle): Yes No Full-time Part time Work Phone: ________________________

Employer: ________________________________ Work Phone: ________________________________

Marital Status: Single □ Married □ Divorced □ Widow □ Partner □ Other: □ ________________

Names of Children (& ages) : ____

Spouse Name: ________________________________ DOB: ________________________ Age:__________

Spouse's SS#: ________________________________ Cell Phone: ________________________________

Spouse's Employer: ________________________________ Work Phone: ________________________________

Primary Insurance

Name of Insurance Plan: ________________________________ Phone # Verifying Insurance: ________________

Certificate/ID Number: ________________________________ Group Number: ________________________________

Subscriber: ________________________________ Relationship: ________________________________

Subscriber's SS#: ________________________________ Subscriber's DOB: ________________________________

Subscriber's Employer: ________________________________ Work Phone: ________________________________

Secondary Insurance

Name of Insurance Plan: ________________________________ Phone # Verifying Insurance: ________________

Certificate/ID Number: ________________________________ Group Number: ________________________________

Subscriber: ________________________________ Relationship: ________________________________

Subscriber's SS#: ________________________________ Subscriber's DOB: ________________________________

Subscriber's Employer: ________________________________ Work Phone: ________________________________

I authorize Dr. Avery to notify my primary care physician (PCP) and referring physician that I'm **receiving services.** Yes No

I authorize Dr. Avery to release/obtain clinical information regarding my **treatment** to my **psychiatrist**. Yes No

I authorize Dr. Avery to release/obtain clinical information regarding my **treatment** to my **PCP**. Yes No

Information to my M.D./insurance may be faxed & e-mailed. Yes No

I understand that minimal clinical information may need to be released to my health insurer or its managed-care company in order for my claims to be processed and agreed to that release. Yes No

I have been advised by Avery Psychological Services to obtain authorization from my insurance carrier or notify them of my treatment. If I fail to do this I could be financially responsible for services rendered. I authorize Dr. Avery to release information to my insurance company in order to obtain payment or authorization for services. I understand and give permission that Dr. Avery may be required by my insurance company to release personal and otherwise confidential information. I absolve Dr. Avery from any responsibility for any misuse of confidential information by my insurance company, included but not limited to the sharing of information with other insurance companies and with employers. I authorize payment to go directly to Dr. Avery

Signature of Client ______________________ Print Name ________________________ Date______________