Child Registration **Avery Psychological Services** Authorization # _____

CHILD'S NAME First Last _____ Age____ DATE OF BIRTH _____ SS# _____ GRADE __

Female □ Male □ Child's Cell Phone (____) _____ **CUSTODY**

Home Phone (____) _____ **PHYSICAL** : Joint □ Mom □ Dad □

LEGAL : Joint □ Mom □ Dad □

Child's MD/Town/Phone _____ Party responsible for payment: _____

MOTHER Whereabouts unknown □

Name _____

Address _____

City/ State /Zip _____

Social Security Number _____

Date of Birth _____

Occupation _____

Cell Phone _____

Home Phone _____

Work Phone _____

Employer _____

Employer Phone _____

EMERGENCY CONTACT: Name: _____

Phone _____ Relationship _____

Medical Insurance Company _____

Medical Insurance Company Phone _____

Subscriber's Name _____

Insurance ID Number _____

Policy/ Group # _____

I give permission for my child to be treated by Dr. Avery.

⊗ _____

Mother/ Guardian Signature Date

FATHER Whereabouts unknown □

Name _____

Address _____

City/ State /Zip _____

Social Security Number _____

Date of Birth _____

Occupation _____

Cell Phone _____

Home Phone _____

Work Phone _____

Employer _____

Employer Phone _____

EMERGENCY CONTACT: Name: _____

Phone _____ Relationship _____

Medical Insurance Company _____

Medical Insurance Company Phone _____

Subscriber's Name _____

Insurance ID Number _____

Policy/ Group # _____

I give permission for my child to be treated by Dr. Avery.

⊗ _____

Father/ Guardian Signature Date

I authorize Dr. Avery to notify my child's Primary Care Physician (PCP) that s/he is receiving services. Yes □ No □

I authorize Dr. Avery to release clinical information regarding my child's treatment to her/his PCP. 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 the claims to be processed, and I agreed to that release. Yes □ No □

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

I authorize Dr. Avery to obtain and release information to the referring physician if there is one. 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

⊗ _____

Mother/ Guardian Signature Date

⊗ _____

Father/ Guardian Signature Date