College Student Registration **Avery Psychological Services** Authorization # __________

PATIENT NAME ______________________________ Date of Birth ________________ Age____ School Year Sr Jr So Fr

CELL (________)__________________ WORK PHONE (________)________________ Student ID # ___________________

Insurance Card ID # __________________________ Party responsible for payment: _________________

PATIENT INFORMATION Female ◻ Male ◻

College/ Local Address P.O. Box Number______________

Dorm / Apartment Address ______________________________

____

City State Zip____________________________________

Social Security Number____________________________________

Mother's Name ____

Mother's Address ________________________________

City State Zip____________________________________

Phone (_______)____

Father's Name ____

Father's Address ________________________________

City State Zip____________________________________

Phone ____

Primary Care Physician ___________________________

Physician Address ________________________________

Phone (_____)________________NPI # ______________

SUBSCRIBER INFORMATION Relationship: Self ◻ Parent ◻ Spouse ◻ Child ◻

Subscriber Name ___________________________________

Address____

City State Zip_______________________________________

Social Security Number ______________________________

Date of Birth __________________________ Age ______

Employer ____

Address ____

City State Zip_______________________________________

Phone (_____)____

Insured Group Number ______________________________

Insurance Plan or Program Name ______________________

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Phone ____

Who should be notified in case of emergency?________________________(_______)______________________________

Name Phone Relationship

______________________________(_______)____

Nearest friend not living with you. Phone Address Relationship

Secondary insurance company to be recorded on second sheet.

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 **treatmen**t 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 ____________