*Gary L. Coats, Ph.D., PA*
*Aspen Counseling Center*
**6901 S. Pierce St**
**Littleton, CO 80128**
**(303) 756-5400/(303) 972-6463 Fax**

# Patient Registration

**PATIENT NAME: _____ AGE: _____ DATE OF BIRTH:_____**

**PARENTS: (if patient is a minor): _____**

**ADDRESS: _____**

**CITY, STATE & ZIP: _____**

**EMAIL: _____**

**HOME PHONE #: _____ WORK or CELL PHONE#: _____**

**MARITAL STATUS: M S D W OCCUPATION/GRADE in SCHOOL: _____**

**REFERRALSOURCE: __ Insurance __ Psychology Today ___ Network Therapy __ Internet**
**__ Other (specify) _____**

**PRIMARY CARE PHYSICIAN: _____ PHONE: _____**

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**PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION**

***INSURANCE *: _____ PHONE #: _____**

**INSURED'S NAME: _____ INSURED'S Date of Birth: _____**

**Social Security # :_____ ANNUAL DEDUCTIBLE:_____**

**MEMBER ID#: _____ IS DEDUCTIBLE MET?: _____**

**EMPLOYER: _____ CO-PAY PER SESSION: _____**

**GROUP #: _____ ANNUAL LIMITS: _____**

**Estimated Family Income: _____**

**I understand that cancellations must be made at least 24 hours in advance. Failure to do so will result in my responsibility for full payment of that session. I authorize the release of any medical information necessary to process this claim. I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to Gary L. Coats, Ph.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.**

**Signature:_____Date:_____**

**(Revised 3/1/17)**