Rachelle A. Sutten, Psy.D.
Aspen Counseling Center
8361 S. Sangre de Cristo Rd., Suite 210
Littleton, CO 80127
(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 ___ Internet ___ Other (specify) _____

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

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:**_____