Rachelle A. Sutten, Psy.D.
Aspen Counseling Center
6901 S Pierce St., Suite 239
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 ___ 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: _____

(Revised 3/1/17)