TODAY'S DATE:	A. Robin Aylor, Ph.D.	ARE YOU A NEW PATIENT? ☐ YES ☐ NO	ID NUMBER	FOR PROVIDER USE ONLY DX:

Patient Information

PATIENT'S NAME			
RESPONSIBLE PARTY'S NAME			
BILLING ADDRESS			
PERMANENT ADDRESS (IF DIFFERENT)			
HOME PHONE ( ) -		WORK PHONE ( ) -	CELL PHONE ( ) -
SEX ☐M ☐F Non-Binary ☐	BIRTHDATE	PATIENT SOCIAL SECURITY NUMBER	RESPONSIBLE PARTY SOCIAL SECURITY #
RELATIONSHIP OF PATIENT TO RESPONSIBLE PARTY ☐ SELF ☐ SPOUSE ☐ CHILD ☑ OTHER (SPECIFY)			MARITAL STATUS ☐ SINGLE ☐ MARRIED

Insurance Information

(Please provide copies of all I.D. Cards—front and back, if applicable)

Please be aware that it is common for insurance companies to subcontract certain benefits to another company. In these instances, we may not bill your insurance company; we may be required to bill your medical group or a third party payer. It is your responsibility to know if this is true. If you are not sure,
I may be able to assist you in learning about this.

☐ **PLEASE CHECK HERE IF YOU HAVE NO INSURANCE AND YOU WILL BE SOLELY RESPONSIBLE FOR PAYMENT.**

PRIMARY INSURANCE NAME			SECONDARY INSURANCE NAME		
INSURANCE PHONE NUMBER ( ) -		EFFECTIVE DATE	INSURANCE PHONE NUMBER ( ) -		EFFECTIVE DATE
CLAIMS ADDRESS			CLAIMS ADDRESS		
CITY STATE ZIPCODE			CITY STATE ZIPCODE		
SUBSCRIBER'S NAME	SEX ☐M ☐F	DATE OF BIRTH	SUBSCRIBER'S NAME	SEX ☐M ☐F	DATE OF BIRTH
SUBSCRIBER'S ID #		GROUP #	SUBSCRIBER'S ID #		GROUP #
SUBSCRIBER'S EMPLOYER	DEDUCTIBLE $	COPAYMENT $	SUBSCRIBER'S EMPLOYER	DEDUCTIBLE $	COPAYMENT $
RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER			RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER		

FOR WORKER'S COMPENSATION INSURANCE ONLY, PLEASE SPECIFY:

DATE OF INJURY _____ STATE IN WHICH INJURY OCCURRED_____

Prior Authorization Information

PRIOR AUTHORIZATION MAY BE REQUIRED BEFORE YOUR FIRST VISIT BY YOUR PRIMARY OR SECONDAY INSURANCE COMPANY. PLEASE BE AWARE THAT IT IS YOUR RESPONSIBILITY TO KNOW IF THIS IS TRUE FOR YOUR INSURANCE COVERAGE, AND TO GET THE NECESSARY AUTHORIZATIONS. IF YOU ARE NOT SURE, I MAY BE ABLE TO ASSIST YOU IN OBTAINING THIS AUTHORIZATION.					
IS AUTHORIZATION REQUIRED FOR YOUR PRIMARY INSURANCE? ☐ YES ☑ NO			IS AUTHORIZATION NECESSARY FOR YOUR SECONDARY INSURANCE? ☐ YES ☑ NO		
PERSON SPOKEN TO:	PHONE NUMBER: ( ) -		PERSON SPOKEN TO:	PHONE NUMBER: ( ) -	
AUTHORIZATION NUMBER	EFFECTIVE DATE	TERMINATION DATE	AUTHORIZATION NUMBER	EFFECTIVE DATE	TERMINATION DATE
NUMBER OF VISITS AUTHORIZED	TYPES OF VISITS AUTHORIZED		NUMBER OF VISITS AUTHORIZED	TYPES OF VISITS AUTHORIZED	

Emergency Contact Information

PRIMARY CARE PHYSICIAN		PHYSICIAN PHONE ( ) -
PRIMARY CARE PHYSICIAN ADDRESS		
MAY WE CONTACT YOUR PHYSICIAN SO THAT THIS PROVIDER MAY BE FULLY INFORMED AND WE MAY COORDINATE CARE FOR YOUR TREATMENT? ☐YES ☐NO		
EMERGENCY CONTACT PERSON		RELATIONSHIP TO PATIENT
HOME PHONE ( ) -	WORK PHONE ( ) -	CELL PHONE ( ) -

Authorization to Release Information, Assignment of Benefits and Certification of Accurate Information

I HEREBY AUTHORIZE THIS MEDICAL PROVIDER TO RELEASE INFORMATION WHICH IS NORMALLY REQUIRED IN THE COURSE OF MY TREATMENT FOR THE SOLE PURPOSE OF PROCESSING ANY CLAIMS SUBMITTED.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THIS MEDICAL PROVIDER. ANY MEDICAL BENEFITS THAT WOULD OTHERWISE BE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY MY INSURANCE CARRIER UNLESS SPECIFICALLY PROHIBITED BY MY INSURANCE PLAN.

I HAVE REVIEWED THE PRECEEDING INFORMATION AND I CERTIFY THAT THIS INFORMATION IS CORRECT. I FURTHER UNDERSTAND THAT THIS INFORMATION IS CORRECT. I FURTHER UNDERSTAND THAT I AM RESPONSIBLE FOR ANY FINANCIAL LOSS DUE TO INACCURATE OR INCOMPLETE INFORMATION PROVIDED BY ME.

PRINTED NAME: _____

SIGNED: _____ DATE: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize _____ to release health information to:
(Name of your Insurance Company)

A. Robin Aylor, Ph.D.
P.O. Box 17025
San Diego, CA 92177-7025

Phone: (800) 460-9219
fax: (800) 460-9219

Type of Record

☐ Medical ☐ Mental Health

Information to be Released

☐ Billing Statements
☐ Consultations/ Evaluations
☐ Discharge Summary
☐ Drug and Alcohol Abuse Information
☐ HIV/AIDS Test Results
☐ Diagnosis and Prognosis
☐ Other (specify)_____
☐ History
☐ Medical Information
☐ Laboratory Reports
☐ Outpatient Clinic Records
☐ Progress Reports
☐ Psychological Test Results
☐ Vocational Evaluation

Specify the date or time for the information selected above to be provided ongoing throughout the duration of treatment.

The purpose of this release is:
☐ at the request of the patient/ patient representative
☒ other (state reason) billing

Dr. Aylor is required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

I understand that this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for 1) conducting research related treatment 2) to obtain information in connection with the eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party.

I may revoke this authorization at any time, provided that I do so in writing.

The revocation will take place when Dr. Aylor receives it, except to the extent that others may have already relied on it.

I am entitled to receive a copy of this authorization.

Expiration of Authorization

Unless otherwise revoked, this authorization expires on: ongoing throughout the duration of treatment

Signature

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Printed name Time am/pm

_____
Relationship to Patient if Other than Patient