

Sarah Ray, Psy.D., QME

Advanced Health Care

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Welcome to ADVANCED HEALTH CARE

PATIENT: This section for the patient only:

Date _____

Name _____ Gender Identification _____ Age _____
Address _____ SS# _____ DOB ____ / ____ / ____
City _____ State ____ Zip _____ Drivers License # _____
Employer _____ Marital Status M S D SEP W
Address _____ Spouse _____
City _____ State ____ Zip _____ Preferred Phone # _____

Emergency Contact: _____

Address _____ Phone # _____

Signature (Please sign here if you authorize Dr. Sarah Ray and/or her associates to contact this person in the case of an emergency). _____

How did you hear about our practice? _____

RESPONSIBLE PARTY FOR BILL if other than patient:

Name _____ Relationship to patient _____
Address _____ Employer _____
City _____ State ____ Zip _____ Address _____
SS# _____ DOB ____ / ____ / ____ City _____ State ____ Zip _____
Home phone # _____ Work phone # _____

Please Check One: Private Insurance () Cash () Other ()

PRIMARY Insurance Carrier

Company _____
Address _____
City _____ State ____ Zip _____
Phone # _____
INSURED _____

(name on insurance card)

Insured's Relationship to Patient:

Self () Spouse () Child () Other ()

MEMBER ID# _____

Primary Member DOB: _____

SECONDARY Insurance Carrier

Company _____
Address _____
City _____ State ____ Zip _____
Phone # _____
INSURED _____

(name on insurance card)

Insured's Relationship to Patient

Self () Spouse () Child () Other ()

MEMBER ID# _____

Primary Member DOB: _____

Authorization to pay benefits to provider: I hereby authorize payment direct to Advanced Health Care of the Insurance benefits otherwise payable to me, and authorize release of information necessary to process a claim with my insurance company. I hereby accept responsibility for any charges not covered by my insurance, and for missed appointments or cancellations with less than 24-hour notice. A copy of this signature is valid as the original. Please also see informed consent document.

Signature _____ Date _____

(If a minor, guardian must sign above and the minor must sign as well providing assent to treat): _____

