Gayle Robbins, Ph.D.

Licensed Psychologist 706.850.9640

1160 S. Milledge Avenue Suite 240 Athens, GA 30605

Phone:

☐ OK to leave message

SUBMISSION OF THIS FORM MUST BE DONE TWO DAYS PRIOR TO APPOINTMENT. FAILURE TO SUBMIT THIS FORM MAY RESULT IN RESCHEDULING. COMPLETION OF THE FORM DOES NOT IMPLY ACCEPTANCE AS A PATIENT.

Client/Billing Information Date / / Note: If you were a client here before, please fill in only the information that has changed. A. Personal Information Your name: ____ Preferred name: MI Last Date of Birth (DOB): ___ Age: _____ **Local Address** Street: Apt. #: City: ____ State: Zip Code: Permanent Address (if different) Street: _____ Apt. #: _____ State: ____ Zip Code:____ City: ___ Home/Evening Phone: ___ Cell phone: ____ ☐ OK to leave message ☐ OK to leave message Gender: _____ Race/Ethnicity: ____ Sexual Orientation: ____ Biological Sex (for insurance purposes): \Box Male \Box Female Preferred Pronoun: ___ Relationship Status: Single Married Partnered Widowed □ Other Religious preference (if applicable): Are you or anyone in your family a Veteran or Active Military? **B. Appointment Reminders:** Our electronic Mental Health Record has the ability to send appointment reminders. Please indicate if you would like such reminders and if so, how you would like those reminders delivered: ☐ Email reminder ☐ Text message reminder (you are responsible for text message rates, depending on your plan) ☐ Please do not send any reminders about upcoming appointments Please indicate the email address or phone to which reminders should be sent. Please initial this line as your consent. _____ B. How Did You Hear about My Practice? If by referral, who gave you my name to call? Phone: May I have your permission to thank this person for the referral? ☐ Yes ☐ No If other source, please indicate. C. Emergency Contact

Relationship:

Clinic/Physician's Name:		Phone:
Address:		
If you enter treatment with me for psycholo physician so that they can be fully informe		maywith your permissioncontact your ordinate your treatment as needed. □ Yes □ No
Psychiatrist's Name:		Phone:
Address:		
If you enter treatment with me for psychology psychiatrist so that they can be fully inform	•	maywith your permissioncontact your coordinate your treatment as needed. ☐ Yes ☐ I
. Current Employer:		
Employer:	Occupation:	Job Title:
How long have you worked for this employer:	Ho	w many hours/week do you work:
Work phone (should I need to contact you): _	Пок	K to leave a message
. Current School:		(to leave a lilessage
	Major:	GPA:
Are you an International Student/Resident?	□ Yes □ No	
Country of Origin:		
How do you plan to pay: ☐ Self Pay/direct p	payment □ Insu	rance
Name of person responsible for payments:		
If you are using Insurance *The information below applies to the policy holder please the indicate the correct policy holder policy holder:	older (person payi olicy holder's name	ng for the insurance plan). If you are not your plan e, DOB, and relevant information below.
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OUTSTANDING BILLS NOT PAID WITHING 90 DAYS MAY ACCRUE A 3% FINANCE FEE