

**D. Craig Kerley, Psy.D.**  
Licensed Psychologist

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Please take a few minutes to complete this form as completely and accurately as possible.  
All information provided is completely confidential.

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**CLIENT INFORMATION**

\_\_\_\_\_  
Last Name                                      First                                      Middle                                      Home Phone Number

\_\_\_\_\_  
Address                                      Apt. #                                      City                                      State                                      Zip Code

\_\_\_\_\_  
Home Telephone                                      Work Telephone                                      Cellular Telephone

\_\_\_\_\_  
Date of Birth                                      Age                                      Social Security Number                                      Sex M/F                                      Marital Status

Employment status:

Full Time    Part Time    Unemployed    Retired    Full Time Student    Part Time Student

\_\_\_\_\_  
School or Employer                                      Occupation

\_\_\_\_\_  
Email Address                                      Education Level

If you have email, may I send billing statements to this email address?                                      Yes    No

\_\_\_\_\_  
Date of Initial Appointment

Is the concern primarily job related?                                      Yes    No  
Related to an accident?                                      Yes    No

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**INSURANCE / RESPONSIBLE PARTY INFORMATION**

\_\_\_\_\_  
How will you be paying? (Insurance, self-pay, etc.)

\_\_\_\_\_  
Insurance Company                                      Telephone Number on Back of Card

\_\_\_\_\_  
Primary Member's Name                                      Primary Member's Social Security Number

\_\_\_\_\_  
Policy Number                                      Group Number                                      Primary Member Date of Birth

Does our office staff have permission to contact your insurance company to verify coverage?    Yes    No  
*(If no, you will be expected to pay in full at each session unless prior arrangements have been made with Dr. Kerley.)*

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## REFERRAL SOURCE

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Name / Organization \_\_\_\_\_ Telephone Number \_\_\_\_\_

Do we have permission to thank them for referring you?    Yes    No

May I consult with them if necessary?    Yes    No

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Signature \_\_\_\_\_

\_\_\_\_\_ Date

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## Please Read and Sign the Following

I hereby authorize Dr. Craig Kerley to furnish my insurance company with all the information they request. I also instruct my insurance company to pay my claim directly to Dr. Kerley where applicable.

I understand that if my insurance requires authorization and I choose to receive service before that written authorization has been received by Dr. Kerley, that I will accept financial responsibility for all charges. I understand that authorization is not a guarantee of payment. I also understand that even if services are authorized, that if I am not eligible on the date of service, or if it is later determined that my policy does not cover the item(s) I am receiving, I may be responsible for payment in full. I further understand that my insurance company may deduct a co-pay, cost share or deductible from their payment to Dr. Kerley, and I agree to pay promptly for these amounts.

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Patient or Legal Guardian's Signature \_\_\_\_\_

\_\_\_\_\_ Date

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Please return this form, along with a copy of the patient's insurance card (front and back) prior to your first session. This form and copy of insurance card may be returned via fax to 678-623-8234 or by email to [info@drkerley.com](mailto:info@drkerley.com).