

Neuropsychological Associates REGISTRATION FORM

(Please Print)

Today's Date:				Appointment Date/Time:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>	
E-mail address:				Birth date:		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Cell phone:							
Street address:			Social Security no.:		Home phone no.: ()		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()		
Chose clinic because/referred to clinic by (Please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance plan	
<input type="checkbox"/> Family		<input type="checkbox"/> Friend		<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages	
						<input type="checkbox"/> Other	
Other family members seen here:							

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist at time of visit.)							
Person responsible for bill:		Birth date:		Address (if different):		Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:		Employer:		Employer address:		Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance or pay source:		<input type="checkbox"/> Aetna		<input type="checkbox"/> BCBS		<input type="checkbox"/> Cigna	
<input type="checkbox"/> Humana		<input type="checkbox"/> LifeSynch		<input type="checkbox"/> Corphealth		<input type="checkbox"/> TWCC	
<input type="checkbox"/> Tricare		<input type="checkbox"/> Self-pay		<input type="checkbox"/> Other			
Subscriber's name:		Subscriber's ID# or SSN:		Birth date:		Group no.:	
						Policy no.:	
						Co-payment: \$	
Patient's relationship to subscriber:		<input type="checkbox"/> Self		<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	
						<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:		Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self		<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	
						<input type="checkbox"/> Other	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):		Relationship to patient:	
Home phone no.:		Work phone no.:	
()		()	
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the practitioner. I understand that I am financially responsible for any balance. I also authorize Neuropsychological Associates or insurance company to release any information required to process my claims. By signing below, I give consent for services and acknowledge receipt of patient's rights and responsibilities.</p>			
<hr style="width: 100%;"/> <i>Patient/Guardian signature</i>		<hr style="width: 100%;"/> <i>Date</i>	

PATIENT'S RIGHTS & RESPONSIBILITIES

INSURANCE BILLING: Neuropsychological Associates (NPA) does bill insurance. Co-payments, if applicable, are to be paid when services are rendered. We will provide patients with receipts that may be submitted to insurance carriers for reimbursement if they chose to self-pay. Patients/Responsible Parties are responsible for all charges whether or not they are covered by insurance, so please check coverage and specifics of mental health/behavioral health plan benefits with your provider.

PAYMENT POLICY: NPA requires payment for services at the time they are rendered. Payments may be made by cash, debit/credit card, cashier's or personal check. Unpaid accounts over 90 days old are routinely reviewed for submission to our collection agency. Patients with out-of-network insurance will be responsible for payment in full at time of service, unless written guarantee of payment is provided by the out-of-network insurance company. The patient is responsible for notification of any changes in insurance and/or personal information.

FEES CHARGED: The fees charged by clinicians at NPA are charged in 45-50 minute increments, depending upon the referral question. Intake sessions may require additional time. Fees beyond the negotiated or allotted rate for insurance contracts are will be discussed prior to treatment. In addition, patients are charged for time spent with clinicians on the telephone, time taken to write reports or correspondence on patient's behalf outside of scheduled appointments, and consultations with other professionals at the patient's request. In the event that your NPA clinician is required to write a legal report, provide a deposition, or testify in court, a different fee schedule will apply. There is a \$35 returned check fee to cover bank charges for all checks returned for non-payment or NSF.

APPOINTMENT CANCELLATION POLICY: NPA is committed to providing quality and timely service to our patients. Therefore, due to the complicated nature of scheduling several appointments and holding appointments to accommodate our patient's needs, in the event that an appointment is not cancelled 24-hours prior and/or rescheduled, a non-refundable charge of \$300 may be required to reserve an appointment slot.

For on-going appointments with our clinicians, NPA requires that cancellations for scheduled appointments be received 24 "business" hours in advance during regular office hours (Monday through Friday 9:00am to 5:30pm). Although emergencies and incidents do occur and NPA will be empathetic and tolerant of such, **missed or habitually late cancelled appointments will be charged to the patient.** Insurance companies do not pay for missed appointment fees and the patient/responsible party is held fully accountable for these charges.

**I HAVE READ AND UNDERSTAND THE ABOVE STATED POLICIES OF
NEUROPSYCHOLOGICAL ASSOCIATES.**

Patient's Name:__

Patient's Signature:__

Responsible Party's Signature:

Date:__