neuroasis
HEALING THE MIND

REGISTRATION FORM (PLEASE PRINT)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single/ Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

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): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No Please indicate primary insurance

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY (THIS IS NOT A HIPAA AUTHORIZATION)

Name of local friend or relative:	Relationship to patient:	Home phone ( )	Work phone ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize NEUROASIS or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

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Authorization to Release Information (Family and/or Friends)

I authorize Neuroasis to release and communicate my healthcare information with the following individuals:

Name	Relationship	Phone Number

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge receipt of the Neuroasis Notice of Privacy Practices.

CONSENT FOR MEDICAL TREATMENT

I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s) at Neuroasis. I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I acknowledge that no guarantees have been made to me as a result of treatments or examination at Neuroasis.

II. **AGREEMENT TO PAY**

I acknowledge and agree that I am responsible for and will pay for all regular charges, which are contained in the applicable Neuroasis pricelist ('chargemaster') which is in effect on the dates of services rendered, for items or services and treatment provided to me, including any amount not paid by my insurance plan. I understand that I can request additional information about all charges for services, or can obtain a non-binding estimate prior, or subsequent, to signing this agreement. I understand that some items or services that Neuroasis may provide to me may not be covered by my insurance carrier, and I agree to be personally responsible for any such non-covered items or services or items or services in excess of the limits in my member benefit agreement. I understand that I am personally responsible for any item or service determined by my third party payor (my insurance company) to be experimental, investigational, or to be non-covered for any other reason.

I understand that I am personally responsible for deductibles and co-insurance established by my member benefit agreement, including those required for in-network laboratory and other ancillary services or items. I hereby agree that if Neuroasis has agreed to bill my insurance or other third-party carrier, it has agreed to do so as a courtesy, and that Neuroasis has the right, should Neuroasis deem it advisable, to demand payment in full from me at any time prior to full payment from any insurance or third-party carrier, unless Neuroasis and my insurance company or third-party carrier have agreed that I will not be billed.

I understand and agree that I have been advised that I may be billed by Neuroasis and that this Assignment of Benefits and Agreement to Pay applies to any and all Neuroasis physician services. If a delinquent account referred for collection, I agree to pay the reasonable attorney's fees, court costs and/or collection agency fees associated with the collection process.

III **ASSIGNMENT OF BENEFITS**

I hereby authorize and request all insurance carriers, health maintenance organizations or managed care organizations with whom I have coverage, to pay directly to Neuroasis. If my health insurance will not allow direct payment to Neuroasis, I agree to immediately forward to Neuroasis all health insurance payments I receive for my care and treatment at Neuroasis.

CONSENT FOR TREATMENT AND AGREEMENT TO PAY

IV. **GUARANTOR AGREEMENT - By signing in the space below as Patient/Legal Representative or Guarantor, I hereby agree that all charges connected with this treatment or any other treatment rendered to the above patient past or future, not covered by any insurance program, sponsorship or other third party coverage I may have are due and payable at the time of discharge or discontinuation of treatment. I understand that upon request I may be given a non-binding estimate of my charges.** I hereby acknowledge that if Neuroasis has agreed to bill my insurance or other third party carrier, it has agreed to do so as a courtesy and that Neuroasis has the right, should Neuroasis deem it advisable, to demand payment in full from me at any time prior to full payment from any insurance or third party carrier, unless Neuroasis and my insurance company or third party carrier have agreed that I will not be billed. I hereby acknowledge having been told that I may be billed by Neuroasis and that this assignment and guarantor agreement shall be allowed to cover any and all

accounts. If the delinquent account is referred for collection, I agree to pay the attorney's fees, court costs and/or collection agency fees associated with the collection process.

PLEASE READ THIS ENTIRE AUTHORIZATION PRIOR TO SIGNING.

Patient/Legal Representative _____ Date _____

(Relationship to Patient) _____

Guarantor _____ Date _____

(If other than patient/legal representative)