

PATIENT REGISTRATION
PLEASE SIGN BOTTOM LINE

Patient's Name: First _____ M.I. _____ Last _____

Street/Billing Address: _____

City: _____ State: _____ Zip: _____ - _____

Main Phone: (_____) _____ Alternate Phone: (_____) _____

SSN: _____ Email Address: _____

Birth Date: _____ Gender: M / F Marital Status: Single / Married / Divorced / Widowed

Responsible Party if Under Age of 18: _____ Relationship to Patient: _____

Referring Physician: _____ Primary Care Physician: _____

Employer's Name: _____ Work Phone: (_____) _____

Emergency Contact: _____ (_____) _____
Name Relationship

Address: _____
Street City State Zip Code

RESPONSIBLE PARTY / INSURANCE GUARANTOR

Name: First _____ M.I. _____ Last _____

Address: _____
Street City State Zip Code

Main Phone: (_____) _____ Email: _____

SSN: _____ Date of Birth: _____ Relationship to Patient: _____

Main Phone: (_____) _____ Alternate Phone: (_____) _____

Employer: _____ Telephone: (_____) _____

INSURANCE INFORMATION

PRIMARY: Insurance Company & ID #: _____

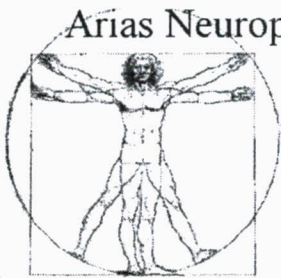
SECONDARY Insurance Company & ID #: _____

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby assign all medical benefits, to include all major benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Arias Neuropsychology & Behavioral Medicine, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. Should it become necessary to turn my account over to an outside collection agency, I will be responsible for collection costs, attorney fees, litigation fees, and court costs. I hereby authorize Arias Neuropsychology and Behavioral Medicine, PC, to release to the insurance companies above or to any other payer (i.e. Attorney, Workman's Compensation Company, etc.), to myself, to my PCP, and to my referring physician, any information necessary for treatment or payment. If I have a liability injury, I understand that I have the option of using my health insurance, if available, or I will be expected to pay for treatment.

Signature: _____ Date: _____

Responsible Party: _____ Date: _____



Arias Neuropsychology and Behavioral Medicine, PC

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CONSENT AND OFFICE POLICIES

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION: By signing this form, you are granting consent to Arias Neuropsychology and Behavioral Medicine, PC to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you read it in full. Our Notice of Privacy Practices is subject to change. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

I acknowledge that I have been offered a copy of Arias Neuropsychology & Behavioral Medicine, P.C. Notice of Privacy Practice Policy, which describes how my health insurance information may be used or disclosed.

NO SHOW AND CANCELLATION POLICY: If you arrive more than ten minutes past your scheduled appointment, you may be considered a no show. We ask for cancellations to occur no less than 24 business hours prior to your appointment, unless there is an unforeseen emergency. Three late cancellations or no shows will result in a release from the clinic and will require a new referral. This policy also applies for any other appointments in this clinic, with any provider. Another outpatient doctor's appointment, lack of transportation, or work conflict is *not* considered an emergency. If an emergency does occur that necessitates canceling the appointment, it is your responsibility to call as soon as possible to let us know. This will give us an opportunity to fill the appointment. **If you no-show for an appointment or cancel less than 24 business hours before an appointment *without* an unforeseen emergency, you will be charged \$50 for *each* hour that was scheduled for you.**

LIMITS OF CONFIDENTIALITY AND CONSENT TO TREAT: Information obtained during assessments and psychotherapy is confidential and can ordinarily be released only with your written permission. There are some special circumstances that can limit confidentiality including: a) a statement of intent to harm self or others, b) statements indicating harm or abuse of children or vulnerable adults, and c) issuance of a subpoena from a court of law. A report is also provided to the referral source, typically for the purpose of treatment, unless you specifically indicate, in writing, you do not wish this to occur.

I agree and consent to participate in behavioral health care services offered and provided at/by Arias Neuropsychology and Behavioral Medicine, PC, to include all its behavioral health care providers. I understand that I am consenting and agreeing only to those services within the scope of the provider's license, certification, and training. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Print Patient Name

Date of Birth

Patient/Responsible Party Signature

Date