

**COUNSELING RESOURCES NEUROPSYCHOLOGICAL ASSOCIATES, LLC
REGISTRATION FORM**

Patient Information:

Name _____ Sex _____ Date-of-Birth ____/____/____
Address _____ City _____ State _____ Zip _____
Who referred patient to our clinic? _____
Status: Minor Adult (choose one): Single Married Separated Divorced Widowed
Primary Care Physician _____ Clinic Location _____
Full-Time Student? Yes No School _____ or Occupation _____
Employer (Name/Address) _____

Who is the contact for this patient?

Yourself : _____ May we leave a message ? _____
HomePhone (____) _____ Yes No
Cell Phone (____) _____ Yes No
Work Phone (____) _____ Yes No Part-time Full-time
Email _____
Other Contact: Name _____ Relationship _____
HomePhone (____) _____ Yes No
Cell Phone (____) _____ Yes No
Work Phone (____) _____ Yes No Part-time Full-time
Email _____

Who has legal authority to consent to treatment? (Indicate number of consent signatures required): _____

Patient (sole authority) Mother (sole authority) Father (sole authority)
Parents (either may consent) Parents (both must sign for consent)
Patient in conjunction with Other
Specify name and Legal Authority of Other _____

If patient is married, has a legal guardian, is a minor or a student please complete this box:

Information for (choose one): Spouse Parent(s) Guardian
Name _____ Date-of Birth _____
Address: Same as Patient _____
Day Phone(____) _____ Evening Phone(____) _____
Employer _____ Occupation _____

For Office Use Only : Mickey _____ Leske _____ Bauman _____ Rhoades _____ Bayless _____ Humphrey _____

Self-pay Patient _____ (____ No Agreement / ____ Has Financial Hardship Agreement for-Fee: \$ _____)

Health Ins Patient _____ EAP Patient _____ WC Patient _____ Legal Firm _____

Front Office Bill: Dodge/LSS _____ County of _____ DVR _____ School Dist of _____ Other _____

Patient Name _____

Registration - Page 2

PATIENT BILLING INFORMATION

Counseling Resources Neuropsychological Associates, LLC will bill your insurance company for professional services rendered, however, the responsible party named on the account remains legally responsible for payment of services. Insurance (third party) billing is a courtesy, and the clinic does not accept responsibility for collection of your claim or for negotiating a settlement on a disputed claim. **Please notify our office immediately if patient changes insurance coverage during the course of treatment.**

Who is ultimately responsible for payment of this account? (please check one)

Self (Adult Patient)

Spouse Only

Guardian

Mother Only

Father Only

Both Parents (Residing Together)

Both Parents (Residing Separately). Mail one bill via: Mother Father Mail Separate Bills

Other (Name & Relationship to Patient) _____

Address: _____

For billing to an insurance other than health insurance, bill to: EAP Workers Comp Ins

WC Case # _____ Case Mgr Name: _____

EAP (Covers _____ number of sessions underauth # _____)

Ins Name/Claims Address _____

Ins Phone# _____ (Subscriber/other # to reference: _____)

Do you plan to use health insurance for payment of services? Yes No

If using health insurance, please provide your insurance ID card(s) to your clinician for copying.

(*Referring MD: _____ UPIN# _____ MA Provider # _____)

Primary Insurance

Insurance Co. _____ Phone No. _____

Claims Address _____ Group #: _____

Subscriber ID or Soc. Sec. _____ *Medicare #: _____

*Medical Assistance #: _____ Policyholder's Name: _____

*Policyholder DOB: _____ Relationship to Patient: Self Spouse Parent Other

Secondary Insurance

Insurance Co. _____ Phone No. _____

Claims Address _____ Group #: _____

Subscriber ID or Soc. Sec.: _____ *Medicare #: _____

*Medical Assistance #: _____ Policyholder's Name _____

*Policyholder DOB: _____ Relationship to Patient: Self Spouse Parent Other

Assignment of Benefits: I hereby authorize Counseling Resources Neuropsychological Associates, LLC to release any medical information necessary to process my insurance claims. I further authorize the above insurance company(s) to make payment directly to the provider for the benefits herein and otherwise payable to me: Signature _____ Date _____

If patient is a minor, parent or guardian must sign)