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, 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____ Rhoades____ Bayless____ Humphrey____ Donath____ Bowser____

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 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 NameClaimsAddress_____
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:_____
*Policy Holder 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_____
*Policy Holder 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)