AUSTIN NEUROPSYCHOLOGY, PLLC

Patient Registration Information For Treatment

Please **PRINT** and complete **ALL** sections below

PATIENT INFORMATION: (If your child is the patient, please provide their information here)

Name: ______________________ ______________________ _____ Sex: ___ MALE ___ FEMALE
LAST FIRST M.I.

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed

Street address: ______________________ Apt # _____ City: ______________ State: _____ Zip ________

Home phone: (_____) ______________ Cell phone: (_____) ______________ Work phone: (_____) ______________

Date of Birth (mm/dd/yyyy) ___/___/______ Social Security #: ______-____-______ Driver's Lic # & State: ______________

Occupation: ______________________ Employer/Name of School: ______________________

Employer address: ______________________ City: ______________ State: _____ Zip ________

FINANCIALLY REPSONSIBLE PARTY INFORMATION (If different from Patient):

Name: ______________________ ______________________ _____ Sex: ___ MALE ___ FEMALE
LAST FIRST M.I.

Relationship to Patient: ______________________

Street address: ______________________ Apt # _____ City: ______________ State: _____ Zip ________

Home phone: (_____) ______________ Cell phone: (_____) ______________ Work phone: (_____) ______________

Date of Birth (mm/dd/yyyy) ___/___/______ Social Security #: ______-____-______ Driver's Lic # & State: ______________

Occupation: ______________________ Employer/Name of School: ______________________

Employer address: ______________________ City: ______________ State: _____ Zip ________

Spouse or other Parent's Name: ______________________

Relationship to Patient: ______________________

Street address: ______________________ Apt # _____ City: ______________ State: _____ Zip ________

Home phone: (_____) ______________ Cell phone: (_____) ______________ Work phone: (_____) ______________

REFERRAL INFORMATION:

Primary Care Physician: ______________________ Phone #: (____)______________

Referred by: ______________________ Phone #: (____)______________

Address: ______________________ City: ______________ State: _____ Zip ________

ALTERNATE EMERGENCY CONTACT:

Name of person not living with you: ______________________ Phone #: (____)______________

Street address: ______________________ Apt # _____ City: ______________ State: _____ Zip ________

Home phone: (_____) ______________ Cell phone: (_____) ______________ Work phone: (_____) ______________

Austin Neuropsychology, PLLC
Tax ID 20-5826539

Patient Name: ______________________________________

Please initial each item to signify agreement and sign below. If you have any questions regarding the policies and procedures of Austin Neuropsychology, PLLC, please discuss them with the office staff or your neuropsychologist.

Acknowledgement of Office Policies and Procedures For Treatment

____ I have read and understand Office Policies and Procedures For Treatment of Austin Neuropsychology, PLLC, including the financial policies, and agree to accept responsibility as described.

Confidentiality Practices and Authorization to Release Health Information:

____ I have read and understand the Confidentiality Policies of Austin Neuropsychology, PLLC which explains how my healthcare information will be used and disclosed. I also grant release of information to the following individuals:

Name: ______________________________	Name: ______________________________
Address: ____________________________ ______________________________	Address: ____________________________ ______________________________
Phone: ______________________________	Phone: ______________________________

Permission to Leave Phone Messages:

____ Austin Neuropsychology, PLLC has permission to leave detailed messages regarding appointments and other aspects of my healthcare at my telephone numbers previously provided.

____ Austin Neuropsychology, PLLC has permission to leave detailed messages regarding appointments and other aspects of my healthcare at this telephone number only: ____________________.

Assignment of Benefits:

____ Assignment of benefits allows Austin Neuropsychology, PLLC to directly bill and be reimbursed by your insurance company &/or Medicare ***if your neuropsychologist participates in these programs***. I hereby give authorization for payment of insurance to be made directly to Austin Neuropsychology, PLLC for services rendered. Authorization is valid indefinitely until revoked in writing.

Research Participation and Teaching:

____ I give Austin Neuropsychology, PLLC permission to use my clinical data for research and teaching purposes.

____ I give Austin Neuropsychology, PLLC permission to contact me with invitations to participate in future research.

By signing this form, you are agreeing to engage in the intervention process. It is expected that you will actively participate in treatment sessions and attend sessions regularly. This will improve the likelihood that you will benefit from treatment; however, progress throughout treatment depends on many factors including motivation, effort, and other life circumstances and, therefore, cannot be guaranteed. If you miss three consecutive sessions, Dr. Paulos will assume that you wish to terminate services and will contact you by letter to verify this. You are free to discontinue treatment at any time without penalty or consequence.

Patient Signature: ______________________________________ Date: ______________

And/Or Legal Representative: ______________________________