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: _______________________________ ____________________________ ______ Nickname: ____________________________
LAST FIRST M.I.

Sex: ___ MALE ___ FEMALE 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 ___________

Email Address: ____

FINANCIALLY REPSONSIBLE PARTY INFORMATION (If different from Patient):

Name: _______________________________ ____________________________ ______ Sex: ___ MALE ___ FEMALE
LAST FIRST M.I.

Relationship to Patient: ____________________________________ Email Address: ____

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: ____________________________________ Email Address: ____

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: (______) _____________________

Patient Name: ______________________________________

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

Acknowledgement of Office Policies and Procedures:

____ I have read and understand Office Policies and Procedures of Austin Neuropsychology, PLLC, including the Confidentiality Policies and the Financial Policies. I agree to these policies as described.

Authorization to Release Health Information:

____ I grant release of information to the following individuals until such release is cancelled in writing:

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. If another number is preferred, list here: _______________________.

Permission to Send Email Messages:

____ Austin Neuropsychology, PLLC has permission to send detailed messages regarding appointments and other aspects of my healthcare at my email previously provided using a HIPPA compliant webmail server.

Permission to Review Radiology Results:

____ I grant the Neuropsychologists at Austin Neuropsychology, PLLC permission to review my imaging results (eg., CT and MRI scans) that may be available through the Austin Radiological Association, Seton Healthcare Network and/or River Ranch Radiology.

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.

Permission to Photograph:

____ I agree for the patient (myself/my child) to be photographed for the medical file.

Research Participation and Teaching:

____ Provided that all identifying information is removed, I give Austin Neuropsychology, PLLC permission to anonymously 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.

Patient Signature: ____ Date:________________

And/Or Legal Representative: ____________________________________