# FALLS NEUROPSYCHOLOGY AND PSYCHOTHERAPY ASSOCIATES, PLLC
# PATIENT REGISTRATION FORM

(Please Print)

| Today's date: | Clinician: |
|---|---|

## PATIENT INFORMATION

| Patient's last name: First: Middle: | ☐ Mr. ☐ Mrs. | ☐ Miss ☐ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
|---|---|---|---|

| Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Gender: ❑ M ❑ F |
|---|---|---|---|---|---|

| Home Telephone: ❑*Preferred #* ❑*Ok to LM* | Work Telephone: ❑*Preferred #* ❑*Ok to LM* | Mobile Telephone: ❑*Preferred #* ❑*OK to LM* |
|---|---|---|

| Street Address: | Social Security Number: |
|---|---|

| P.O. Box: | City: | State: | ZIP Code: |
|---|---|---|---|

Email Address: ❑*Email consent on file*

| Occupation: | Employer: |
|---|---|

| Name of Primary Care Doctor: | Telephone Number | Fax Number |
|---|---|---|

Who referred you to FNPA?

## INSURANCE INFORMATION

(Please give your insurance card to your clinician.) Insurance Company:

Is this visit related to: [ ] Work Related Injury [ ] An Automobile Accident [ ] Neither

| Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( ) |
|---|---|---|---|

| Occupation: | Employer: | Employer address: |
|---|---|---|

| Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $ |
|---|---|---|---|---|---|

| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |
|---|---|---|---|---|

| Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.: |
|---|---|---|---|

| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |
|---|---|---|---|---|

## IN CASE OF EMERGENCY

| Name of local friend or relative: | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( ) |
|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Falls Neuropsychology and Psychotherapy Associates, PLLC. I understand that I am financially responsible for any balance. I also authorize Falls Neuropsychology and Psychotherapy Associates, PLLC and my insurance company to release any information required to process my claims. In case of emergency, I authorize Falls Neuropsychology and Psychotherapy Associates to contact the above named person or designated other on my behalf.

Patient/Guardian signature Date

# Falls Neuropsychology and Psychotherapy Associates, PLLC

**ACKNOWLEDGEMENTS AND CONSENTS**

I have received from Falls Neuropsychology and Psychotherapy Associates, PLLC, access to "Notice of Privacy Practices" and had adequate opportunity to read and review this document.

Signature:_____ Date: _____

I agree to receive treatment from Falls Neuropsychology and Psychotherapy Associates, PLLC. I understand I can withdraw this consent for treatment at any time.

Signature:_____ Date: _____

I authorize Falls Neuropsychology and Psychotherapy Associates, PLLC to leave messages for me, either via voicemail/ answering machine or with a person in my home.

Signature:_____ Date: _____

In order that we may file your insurance for you, please read and initial each line and sign the following signature-on-file form.

___ I authorize use of this form on all my insurance submissions.

___ I authorize the release of information to all of my insurance carriers.

___ I understand that I am responsible for my bill. I agree to pay all copays at the time of service and to pay any outstanding balances within 30 days of receiving a bill. I am aware that if I balances are not paid promptly, Falls Neuropsychology and Psychotherapy Associates, PLLC reserves the right to charge a late payment fee and my account may be submitted to a collection agency.

___ I understand that a claim will only be filed with my primary insurance. When there is a secondary insurance policy, I understand that I will be responsible for submitting any secondary claims for reimbursement. If, as a courtesy, Falls Neuropsychology and Psychotherapy Associates, PLLC does file a claim on my behalf to a secondary insurance and the claim is denied, I agree to reimburse Falls Neuropsychology and Psychotherapy Associates, PLLC for all such charges.

___ I authorize my provider to act as my agent in helping me obtain payment from my insurance carriers.

___ I authorize payment directly to my provider and hereby assign my right to reimbursement for services rendered to Falls Neuropsychology and Psychotherapy Associates,PLLC.

___ I permit a copy of this authorization to be used in placeof the original.

Signature:_____ Date: _____

If you would like to be able to communicate via email, with your clinician or other member of Falls Neuropsychology and Psychotherapy Associates, PLLC, please initial each line and sign below.

___ I authorize Falls Neuropsychology and Psychotherapy to communicate with me and my other health care providers via electronic mail (email). I agree that email messages may include protected health information.

___ I understand that the confidentiality of email cannot be guaranteed and I hereby release Falls Neuropsychology

and Psychotherapy Associates, PLLC and all from any and all liability that may arise from the release of information as I have directed.

___ I understand that I have the right to revoke this Authorization at any time. I understand that if I revoke this Authorization, it will not apply to any information previously released as a result of this Authorization. I understand that I may refuse to sign this Authorization.

___ I understand that once the information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

Signature:_____Date: _____

Falls Neuropsychology and Psychotherapy Associates, PLLC accepts multiple forms of payment. For your convenience, we offer the option of automatic draft on a credit card or debit card. Copays can be charged automatically keeping your account up to date. This option can also be used to make automatic payments to help clients who have a large deductible or other large balance. Please complete and the following information and initial each line as appropriate to utilize this option:

___ I authorize Falls Neuropsychology and Psychotherapy Associates, PLLC to charge my credit or debit card as follows:

___ Weekly or monthly copay/ coinsurance of _____.

___ Weekly or monthly payment of _____ until balance is paid in full.

I understand that I can withdraw this consent at any time by requesting to do so in writing. Such cancellation will only effect transactions after the date of cancellation.

Type of Card: _____

Card Number: _____ CVV Code: _____

Name on Card: _____ Exp. Date: _____

Signature:_____Date: _____

I have been provided access to a copy of the Policies and Procedures and my provider has reviewed relevant Policies and Procedures including the need for 24 hour cancellation notice to avoid a cancellation charge; and of the differences between therapeutic, evaluation, and forensic services. I agree to these policies and my preference for payment is as follows (Please initial option to be utilized):

___ Pay each visit in full (with no insurance claim filed by Falls Neuropsychology and Psychotherapy Associates, PLLC)

___ Pay my insurance co-payment and other fees each session (or utilize my EAP/ MOS benefit) and have my insurance filed for me.

___ Make an alternate payment plan that must be specific andreceive prior approval from the directors of Falls Neuropsychology and Psychotherapy Associates, PLLC.

Signature:_____Date: _____

Clinician's Signature & date: _____

# Falls Neuropsychology and Psychotherapy Associates, PLLC

8388 Six Forks Road
Suite 104
Raleigh, NC 27615

Tel. (919) 870-0264
Fax. (919) 870-0293

## Consent for Other Offices to Release Information and Records
### to Falls Neuropsychology and Psychotherapy Associates, PLLC

I hereby authorize the release of information from the medical records of and/or disclosure of protected health information for:

Name: _____ Social Security #: _____ Date of Birth _____/_____/_____

Purpose of Disclosure: _____

Dates of Service: _____

This information is to be released to Thomas Bundick, Ph.D. / Denise Bundick Ph.D. (please circle) of Falls Neuropsychology and Psychotherapy Associates, PLLC.

I understand the personal health information disclosed may include information regarding psychological or psychiatric impairment, substance abuse, Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV). I understand that I may revoke this consent at any time except to the extent that the information has already been released pursuant to this consent before its revocation. Otherwise, this consent shall continue to be valid only as long as is reasonably necessary to carry out the purposes enumerated above or one year after the date signed, whichever is the earliest date.

_____/_____/_____
Patient/Representative Signature Relationship Date signed

If you signed as a representative of the patient, read the following and sign below:

I, _____, hereby certify and attest that I am the duly authorized personal representative of the above patient, and that I have the lawful authority to enter into this authorization on behalf of such individual. I have read the provisions set forth in this authorization, and agree that the recipient of this consent form may disclose the medical record information of such individual for the purposes set forth herein.

_____/_____
Signature Date signed

I understand that if information disclosed pursuant to this authorization is re-disclosed by me/us, that information would no longer be protected under the terms of the federal privacy rule.

# Falls Neuropsychology and Psychotherapy Associates, PLLC

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## Consent for FNPA to Release Your Information and Records

I, _____ (Date of Birth :_____), hereby authorize _____ of Falls Neuropsychology and Psychotherapy Associates, PLLC, to release my records and reports pertaining to my treatment, beginning with my first appointment on _____, to the following parties:

Name: Address:

_____

_____

_____

for the following purpose, use, or need:

- ☐ Coordination of treatment
- ☐ Provision of information to other professionals
- ☐ other _____

The following information from my records may be disclosed:

- ☐ General Protected Health Information (PHI) (Demographic data, dates of service, diagnosis, evaluation reports, treatment plans, global assessment of treatment progress)
- ☐ Psychotherapy notes
- ☐ Verbal Exchange of PHI

I understand that this authorization may be withdrawn by me at anytime. Revocation of this authorization will not affect any information already released. I hereby certify that I am 18 years of age or older. Unless this form is previously revoked in writing, this release of information will remain in force until twelve months from the date of signature.

_____

Signature of Patient Date

_____

Witness Date

**Consent by Person Other than Patient**

If patient is under 18 years of age or otherwise unable to consent, the following must be completed:

I, _____, certify that I am the _____ of the patient; that the patient is unable to consent because he or she is a minor, _____ years of age, or because _____.

_____

Signature of Parent or Guardian Date

_____

Witness Date