Arrowhead Psychological & Behavioral Sciences, LLC

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Child Neuropsychological Evaluation Registration Form

Instructions: Please complete all sections. Write "same" if information is contained in, or the same as, previous sections.

Child Name ______________________ DOB__________________

Mailing Address ______________________ Home Phone_______________

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Child SS# ______________________

Primary Care Doctor ____

Other Doctors or Individuals (who should receive a copy of the report of the findings from this evaluation).

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Parent/Guardian Name ______________________ Home Phone ______________________

Mailing Address ______________________ Work Phone ______________________

(if different) ______________________

Teacher Name (if applicable) ______________________ School Name ______________________

Mailing Address ______________________ School Phone ______________________

______________________ Grade ______________________

Daycare Provider Name (if applicable) ______________________ Daycare Name ______________________

Mailing Address ______________________ Daycare Phone ______________________

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Reason for Referral

Please describe the reasons you are requesting this evaluation: ______________________________

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Who referred you to our clinic? ______________________________________

Please read and sign the back of this form.

Clinic Policies

The service today will be billed by the hour at a rate of $250/hour. In accordance with CMS standards of practice, billing for neuropsychological assessment will include time to administer tests, score tests, review records, interpret tests, conduct interviews, prepare the report, and provide necessary feedback to the patient/family. For non-forensic cases, this will typically add 6 - 12 hours to the actual testing time. Forensic/medical/legal cases typically require more time and may include extensive record review and consultation(s) with attorney(s), etc.

You are required to pay all deductibles, co-pays and coinsurance amounts. Your insurance policy is a contract between you and your insurance company. You are ultimately responsible for any balance not covered by your insurance policy. As a courtesy, we will bill your insurance for you. We will make every effort to ensure that claims are complete and accurate when submitted; however, follow up on your insurance claim is your responsibility. **If your insurance does not reimburse us within 60 days, you will become responsible for the balance**; you will be refunded any amount subsequently received by your insurance company.

In certain circumstances, we will make arrangements for a payment plan. However, it is generally unethical and/or illegal for us to waive your co-payment and/or deductible.

We are pleased you have chosen to come to our clinic. Please do not hesitate to request clarification of any clinic policies or ask any other questions regarding your service. Dr. Roche is happy to respond to any concerns.

Guarantee of Payment and Assignment of Insurance Benefits

For value received, the undersigned guarantor (hereinafter “the Undersigned”) and/or patient (hereinafter “the Patient”) promises to pay to Arrowhead Psychological & Behavioral Sciences, LLC (hereinafter “Provider”) all charges incurred for services rendered to the Patient. The Undersigned understands that Provider will process the paperwork to complete insurance claim(s) as a courtesy to the Undersigned, and the Undersigned and/or the Patient authorize Provider to release any and all medical information necessary to complete insurance claim(s) and assigns any monies due and owing under the insurance contract to said Provider. It is, however, understood and agreed that the Undersigned is responsible for all monies due and owing for services rendered by Provider in the event insurance does not pay for these services. It is acknowledged that completing and following-up of any insurance claims is ultimately the responsibility of the Undersigned. It is further agreed by the Undersigned that in the event any monies received by Provider from the insurance carrier are at any time after their receipt withdrawn from Provider by the insurance carrier, the Undersigned will be responsible for those monies then due and owing, and waives any defense for payment the Undersigned may have against Provider. In the event this account is turned over to an attorney for collection, the Undersigned hereby agrees to pay all costs of collection, not limited to court costs but including reasonable attorney’s fees. The Undersigned and/or Patient authorize use of this form of all insurance claim submissions. Your signature indicates you have read the above and agree to the terms contained therein. This agreement is irrevocable.

Date ______________________ Responsible Party Signature ____

Relationship to Patient ____