San Francisco Neuropsychology

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FILL OUT COMPLETELY - IF INCOMPLETE, CLAIMS WILL NOT PROCESS,
AND INSURED WILL BE RESPONSIBLE FOR CHARGES

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Social Security Number: _____ Sex: M___F___ Marital Status: _____

Home Address:_____ City: _____ Zip: _____

Home Ph: ( ) _____ Cell Phone: ( ) _____

Employer Name: _____Work Number: _____

INSURANCE INFORMATION (ATTACH COPY OF INSURANCE CARD FRONT AND BACK)

Primary Insurance: _____ Type of plan:_____

Insurance Address: _____City/State/Zip:_____

Insured Name: _____ Relation to patient: _____

Insured Date of Birth: _____ Insured Social Security Number: _____

ID#:_____ Group #:_____ Effective Date: _____

Insurance Phone #: _____ Employer: _____

Secondary Insurance: _____ Type of plan:_____

Insurance Address: _____City/State/Zip:_____

Insured Name: _____ Relation to patient: _____

Insured Date of Birth: _____ Insured Social Security Number: _____

ID#:_____ Group #:_____ Effective Date: _____

Insurance Phone #: _____ Employer: _____

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____ insurance company (ies) and assign directly to SF Neuropsychology PC all insurance benefits, if any, otherwise payable by me for services rendered. I understand that I am financially responsible for all charges whether paid by the insurance or not. I hereby authorize the doctor/clinician to release all information necessary to secure the payment of benefit. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

SIGNATURE OF RESPONSIBLE PARTY RELATIONSHIP DATE SIGNED

PATIENT FINANCIAL AGREEMENT

CONFIDENTIALITY:

I understand that my records are confidential and will not be released to outside individuals of agencies without written consent. However certain information may be released without my authorization under the following circumstances:

1. In the event of a medical emergency.
2. If there is evidence of child abuse, dependent or elder abuse.
3. When a hazard to the public requires disclosure.
4. When there is an indication that I will likely harm myself.

TELEPHONE CONSULTATIONS:

I understand that telephone consultations are not covered by Medicare and other health plans. Therefore, I understand that telephone contacts beyond appointment scheduling may result in a charge equivalent of $200.00 per hour for the duration of call. Our office does provide a free 10-15 minute consult prior to scheduling, but after scheduling, the rate applies.

FINANCIAL RESPONSIBILITY:

I understand that I am responsible for obtaining all necessary referrals prior to scheduling an appointment for neuropsychological testing or CBT therapy. All co-pays required by my Insurance Plan will be paid at the time of service. I further acknowledge that all deductibles, co-insurance, and non-covered items as determined by my insurance plan will be due and payable upon notice either sent by US Mail in the form of a statement and/or communication from San Francisco Neuropsychology PC. Any balances not paid within 30 days from the day the statement is sent will result in an additional $12.00 fee.

CANCELLATIONS:

Appointments are regarded as contract for the exclusive use of the doctor's time. I understand that regular charges may be applied to missed appointments without 72 business hours advance cancellation notice. I understand that my insurance carrier will not pay for my absence and I will be responsible for these charges. Excessive cancellations will require a credit card on file before any further scheduling can proceed. No shows/ late cancellation will result in a $75 fee.

FINANCIAL ESTIMATE:

Out of pocket estimate for Blue Shield Policy Holders can range from $600-$4,000.

Signature:_____ Date:_____

(I understand my financial and business agreements listed)

PAYMENT OPTION:

I AUTHORIZE MY CREDIT CARD TO BE BILLED FOR ANY AND ALL OUT-OF-POCKET CHARGES THAT MAY BE INCURRED.

VISA / MASTERCARD (circle one) Card #_____

EXPIRATION: _____ CVV # _____ Billing Zip Code _____

SIGNATURE: _____ DATE: _____

A valid credit card on file is mandatory with proceeding.