Associates in Neuroscience

Thomas Pallardy, Psy.D.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: ____

Date of Birth: _____/_____/_____ Sex: **M F Other** Best Phone #: _____

Address: _____ City:_____ Zip:_____

Email: _____

Emergency Contact:_____ Phone: _____

The office has a small therapy dog, are you comfortable with him during your visit? ☐ YES ☐ NO

Primary Care PHYSICIAN

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

REFERRING PHYSICIAN

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

PARENT/GUARDIAN INFORMATION (IF PATIENT IS A MINOR)

Relationship to Patient: ☐ Mother ☐ Father ☐ Guardian ☐ Other: _____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Sex: _____ Phone: _____ Alt: _____

Address: _____ City:_____ Zip:_____

Cell Phone: _____ Work Phone: _____

*Please Note Dr. Pallardy is NOT In-Network with HMO insurance at this Location

PRIMARY INSURANCE INFORMATION

Ins Co. Name: _____

Name of Policy Holder: _____ DOB: _____

Policy Holder Address: _____

Relationship to Patient: _____ Policy# _____ Group # _____

STATEMENTS

Who will be responsible for this bill? _____

Address: _____ Phone: _____

I have read and understand all of the above information and hereby state that the information is correct to the best of my knowledge.

Signature: _____ Date: _____

Name: _____ Relation to Patient: _____

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PATIENT PAST MEDICAL HISTORY FORM

Reason for Visit: _____

CURRENT PROVIDERS

Please list all of your child's physicians:

Physician	**Specialty**

MEDICATIONS

Please list all medications (both prescription and over the counter) that your child is on:

Name of Prescription & Dose	**Reason**

ALLERGY HISTORY

Medications

_____

_____

_____

Environmental

_____

_____

Patient Name: _____ **DOB:** _____

Parent/Guardian Signature: _____ **Date**: _____

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Office Policies

Associates in Neuroscience appreciates the confidence you have shown in choosing us to provide for your health care needs. The medical service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment of your account. As a courtesy, we will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. It is your responsibility to provide your current insurance, including any secondary policy. In the event your insurance is not current and valid, or your coverage has terminated there may be a re-billing fee of 1% of the total charges for all claims affected. If you do not have valid and current insurance at the time of service, you will be solely responsible for the full amount of the office visit and/or any procedures rendered. If you sustain a balance of $250.00 or more over a 30 day period, you will not be rescheduled until the balance has been paid. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, we will start the appeal process for you if you have signed an Authorized Representative Request, and we will take all steps allowed by your insurance. However, you will be responsible for your balance in full if the appeal process is unsuccessful.

In-Network Insurance Coverage:

Patients who are in-network will either will be required to pay a copay or a deductible. A copay plan is a set amount which your insurance company requires us to collect at the time of each office visit/service. A deductible plan is billed to your insurance carrier to determine payment of services and any remaining balance is the patient's responsibility.

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. Our office has a 24-hours cancellation policy, if you cancel an appointment without adequate notice (24 hours), or if you do not attend an appointment, a no-show fee of $50.00 will be charged. The no- show fees **are not** covered by insurance and will be your full responsibility. Our office currently requires you to keep a credit card on file for this fee.

Self-Pay

If you do not have health insurance, you will personally be financially responsible for services rendered at Associates in Neuroscience, SC. You must pay Associates in Neuroscience, SC the full and entire amount of treatment given to you or to the patient at each visit.

I have read, understand, and agree to the terms of the above office policies found on this sheet, given to me regarding my financial responsibilities to Associates in Neuroscience, SC for providing services to me or to the patient I am signing for.

Patient Name: _____ DOB: _____

Patient/Authorized Signature: _____ Date: _____

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Credit Card Authorization Form

I authorize Associates in Neuroscience, SC to process payments on my VISA, MASTERCARD, DISCOVER or AMERICAN EXPRESS for my visits with Thomas Pallardy, Psy.D. at Associates in Neuroscience for co-pays, co-insurance, failed appointment / late cancellations charges and outstanding balances. I understand that my outstanding account balance may be run with the information that I leave on file.

I understand that if my card declines, Associates in Neuroscience, SC may put my VISA, MASTERCARD, DISCOVER or AMERICAN EXPRESS through on another day when funds become available. If my account balance gets high enough, I understand that my services at Associates in Neuroscience, SC will be put on hold until I can make arrangements with a payment plan or pay my balance in full.

_____ _____

Patient Name Date of Birth

_____

Cardholder Name

_____ _____

Card Number Expiration Date

_____

Billing Address (Street, City, State, & Zip Code)

_____ _____

Patient/Guardian Signature Today's Date

_____ _____

Parent Signature (If patient is under 18 years of age) Today's Date

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PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT:

I hereby consent to the treatment provided by Associates in Neuroscience and its employees and designees (Referred to as "the Practice"). I authorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION:

I authorize the use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the practice. I authorize the Practice to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the practice may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent.

ASSIGNMENT OF INSURANCE BENEFITS / PAYMENT GUARANTEE /COLLECTION FEE:

I authorize payment to be made directly to the Practice for insurance benefits payable to me. I understand that I am financially responsible to the Practice for any covered or non-covered services (including EEGs and any other procedures), as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney's fees.

PRIVACY POLICY:

I acknowledge that I have received a copy of this authorization and agreement. I understand that Associates in Neuroscience, SC has the right to change this Privacy Practice from time to time and that I may contact Associates in Neuroscience at any time to obtain a current copy of the Privacy Practices.

Patient Name: _____ DOB: _____

Patient/Authorized Signature: _____ Date: _____

Relationship to Patient: _____