BOSTON NEUROPSYCHOLOGICAL SERVICES, LLC.

Phone 781 559 8444 | test@bostonneuropsych.com | 687 Highland Ave/Fl 2
Fax 781 559 8117 | http://www.bostonneuropsych.com | Needham, MA 02494

PATIENT REGISTRATION

TODAY'S DATE:
PATIENT'S NAME:
ADDRESS:
CITY:
MAILING ADDRESS (if different):

DATE OF BIRTH:
SEX: ☐ M ☐ F ☐ Other
STUDENT? ☐ Yes ☐ No
TEL. (home):
STATE & ZIP:

RESPSONSIBLE PARTY: (who is responsible for payment of all costs incurred)

NAME:
ADDRESS:
CITY:
STATE & ZIP:
PATIENT'S RELATIONSHIP:
☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER:

DATE OF BIRTH:
TEL (Home):
TEL (Cell):
TEL (Work):

Email Address:

INSURANCE

PRIMARY INSURANCE CO.
INSURANCE PHONE NO:
SUBSCRIBER NAME:
SUBSCRIBERS ADDRESS:
CITY:
SUBSCRIBER EMPLOYER:
PATIENTS RELATIONSHIP TO INSURED:
☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER:

INS. ID NO.
GROUP NO.
DATE OF BIRTH:
STATE & ZIP:
EMPLOYER TEL:

SECONDARY INSURANCE CO.
INSURANCE PHONE NO:
SUBSCRIBER NAME:
SUBSCRIBERS ADDRESS:
CITY:
SUBSCRIBER EMPLOYER:

INS. ID NO.
GROUP NO.
DATE OF BIRTH:
STATE & ZIP:
EMPLOYER TEL:

PATIENTS RELATIONSHIP TO INSURED:

☐SELF ☐SPOUSE ☐CHILD ☐OTHER:

THIRD PARTY INFORMATION

WERE YOU INJURED WHILE WORKING? (Workers' Comp) ☐ No ☐Yes → Date of injury:

WORKERS COMP. INS. CO. CLAIM ID NO.

INSURANCE PHONE NO. ADJUSTER'S NAME:

MOTOR VEHICLE ACCIDENT? ☐No ☐Yes → State: Date of Accident:

AUTO INSURANCE COMPANY: CLAIM ID NO.

INSURANCE PHONE NO: ADJUSTER'S NAME:

OTHER ACCIDENT? ☐No ☐Yes → DATE OF INJURY:

ARE YOU REPRESENTED BY AN ATTORNEY? ☐ No ☐ Yes →

ATTORNEY'S NAME: PHONE NO:

ADDRESS:

GUARANTEE OF PAYMENT AND ASSIGNMENT OF INSURANCE BENEFITS: For value received, the undersigned guarantor and/or patient (hereinafter the "Responsible Party") promises to pay to Boston Neuropsychological Services, LLC. (hereinafter "BNS") all charges incurred for services rendered to the patient. The Responsible Party understands that BNS will process the paperwork to complete insurance claim(s) but only as a courtesy to the Responsible Party, and the Responsible Party authorizes BNS 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 BNS. **It is, however, understood and agreed that the Responsible Party is responsible for all monies due and owing for services rendered by BNS in the event insurance does not pay for these services.** It is acknowledged that the ultimate completing and following-up of any insurance claims is the responsibility of the Responsible Party and agrees that accounts that are not paid within (60) days will accrue interest at the rate of **1.5% per month (18% A.P.R. - a minimum of $1.00 will apply).** In the event this account is turned over to an attorney and/or collection agency for collection, the Responsible Party hereby agrees to pay all costs of collection including, but not limited to, court costs and attorney's fees. The Responsible Party authorizes use of this form on all insurance claim submissions. Release of records to referral sources is also authorized. The Responsible Party agrees to be bound by the terms and conditions of this account with BNS.

SIGNATURE: _____ DATE:

PRINTED NAME:

LATE CANCELLATION POLICY ON THERAPY/FEEDBACK APPOINTMENTS: A minimum of 24 hours' notice is required for cancellation of appointments. If this notice is not received, the Responsible Party will be charged for the full amount of time which was reserved for the appointment at the rates posted in the office of BNS.

SIGNATURE: _____ DATE:

PRINTED NAME:

THIRD PARTY CLAIMS AGREEMENT: The Responsible Party bears ultimate financial responsibility for all services rendered to the Patient/Responsible Party, including workers' compensation claims and personal injury cases, regardless of the outcome of litigation. In the event that coverage is denied under workers' compensation, the Responsible Party will pay any unpaid balance, notwithstanding any appeal of such denial. With respect to personal injury cases, the Responsible Party is responsible for fees incurred, BNS may not be able to seek payment from third parties, and BNS cannot wait on the outcome of pending litigation for payments. BNS does not accept contingency fee arrangements, if there is any remaining balance(s) due at the time of settlement, the Responsible Party hereby authorizes their attorney to pay the full amount of any outstanding amount with BNS. In the event the Responsible Party has "**medpay**" available and health insurance, BNS considers medpay to be the primary insurer. The Responsible Party's signature also constitutes the irrevocable agreement to a waiver permitting payment of medpay insurance claims and/or personal injury protection benefits sent directly to BNS prior to claimant receiving such funds.

SIGNATURE:_____ DATE:

PRINTED NAME:

To be completed in instances in which parents are divorced, separated, or never married; or in which care is being sought for a foster child.

I _____ hereby attest that I am the legal guardian of

_____(DOB; __/ ___/_____),

and am thereby empowered to make all decisions pertaining to this child's health and educational needs, including psychological and neuropsychological services. In addition, I attest that no court order or custodial agreement limits my powers in this regard or requires additional consent from another party.

Name (printed)_____Date:_____

Signature:_____

In the space below, please provide the name, address and telephone number of the parent/guardian residing elsewhere:

_____