Provider Name

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Complete Neuropsychology Services, Inc
2010 Hogback Rd, Ste 6G Ann Arbor, MI 48105
1056 Orndorf Dr, Ste G Brighton, MI 48116

PATIENT INFORMATION

Last Name____ First______________________________MI_____________

Street Address____City_________________State_____________Zip_____________

Home Phone_____________________ Cell Phone_______________________ Email Address_________________________________

Communication Preferences: **Ok to leave phone message?** Yes ☐ No ☐ **Ok to text message?** Yes ☐ No ☐ **Ok to email** Yes☐ No ☐

Gender as enrolled with insurance company ______Female _____ Male Language Preference _________________________

Date of Birth_________________________________Age__________ Preferred Pronouns __________________________

Race: __Asian ___ American/Alaskan Indian ___ Black/African American ___ Hawaiian ___Other/Unk ___White ___Declined

Ethnicity: _____Hispanic / Latino _____Non Hispanic /Non Latino ____Declined

GUARANTOR INFORMATION

LEGAL GUARDIAN, OR WHOMEVER BRINGS IN MINOR CHILD OR INCAPACITATED ADULT, MUST COMPLETE THIS SECTION

Last Name____ First______________________________MI_____________

Street Address____City_________________State_____________Zip_____________

Home Phone_____________________ Cell Phone_______________________ Email Address_________________________________

Communication Preferences: **Ok to leave phone message?** Yes ☐ No ☐ **Ok to text message?** Yes ☐ No ☐ **Ok to email** Yes ☐ No ☐

Date of Birth_________________________________Age__________ Language Preference _______________

Release of Information to Third Party Payors/Agents & Authorization and Assignment of Benefits Agreement for Payment of Services:

I authorize my provider to disclose portions for the clinical record on the client named below to my insurance company and/or its contracted managed care/utilization review company for the purpose of reimbursement of services rendered at this facility. Such disclosure may include review and release of copies of psychiatric/psychological and/or substance abuse diagnosis, history & physical examinations, intake assessment, treatment plan, progress notes, testing results, discharge summary and any other information or records necessary for the discharge of the legal contractual obligations of the insurance company.

I hereby release my provider and its' officers, agents, employee and any clinician associated with my case from all liability that may arise as a result of the disclosure of information to the insurance company and/or its contracted managed care/utilization review company.

By signing this release, I acknowledge the following:

1. I am aware that I may revoke this authorization at any time except to the extent that action has been taken in reliance hereon.
2. I agree that this authorization will be valid during the pendency of the claim.
3. I further authorize that payment be made to my provider of service on my behalf.
4. I understand that I am financially responsible for all charges not covered by insurance and/or those stated to be patient responsibility by the third party payor.
5. I understand that any expense that is incurred by my provider associated with collecting the balance on my account, such as collection fees and/or attorney's fee will be my responsibility to pay.

Patient OR Guarantor Signature (if patient is a minor or incapacitated adult)____Date________________

Medicare Authorization and Assignment of Benefits: (MEDICARE PATIENTS ONLY)

I request that payment of authorized Medicare Benefits be made either to me or on my behalf for any services furnished by or in the office of my provider of service. I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefit of related services.

Signature____ Date___________________________________

COPY OF INSURANCE CARD MUST BE ATTACHED