AAA Neuropsychology, LLC
59 General Warren Blvd · Suite 101 · Malvern, PA 19355
Phone: 484-870-5608 · Fax: 484-870-5609

Client Information and Authorization Form

Today's date: ___________________

A. Identification:
Your name: ____ Date of birth: ____________________ Age: ________

Nicknames or aliases: ____ Social Security #: ______________________________

Home street address: ____ Apt.: ____________________

City: ____ State: _____ Zip: ___________________

Home/evening phone: _________________________________ Cell/e-mail: ____

Calls or e-mail will be discreet, but please indicate any restrictions: ____

B. Referral: Who gave you our contact information?

Name: ____ Phone: _______________________________

Address: ____

May we have your permission to thank this person for the referral? ❑ Yes ❑ No
How did this person explain how we might be of help to you? ____

____

C. Your medical care: From whom or where do you get your medical care?
Clinic/doctor's name: ____ Phone: ______________________________

Address: ____

May we keep your medical doctor fully informed about your evaluation to coordinate your treatment? ❑ Yes ❑ No

D. Emergency information
If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?
Name: ______________________________________ Phone: ______________________ Relationship: ___________________

Address: ____

Significant other/nearest friend or relative not residing with you: ____

E. Payment information

Primary Insurance

Health insurance carrier/company name: ___________________________________ Policy #: __________________________

Name of policyholder (if not the patient): ____________________________Policyholder's date of birth: __________________

Policyholder's SSN:____________________________Relationship to patient: ____

Policyholder's address: ____ Phone # of provider services & mental health (back of card): ____

If you have a copay, please indicate amount $ ___________ and method of payment ________________________________

Secondary Insurance

Health insurance carrier/company name: ____

Name of policyholder (if not the patient): ____________________ Policy#: ____________________

If you do not have insurance, how will you pay for services from this office? ____________________

If Accident, please indicate date of accident: ____

Attorney name: ____________________ Telephone: ____________________

Address: ____

F. Confidentiality and Authorization:

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what assessment or treatment is best for you and to provide those services to you. We may also share this information with others to arrange payment for your assessment or treatment, to help carry out certain business or government functions, or to help provide other services for you. By signing this form, you are agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

Information obtained during assessment or treatment is confidential and can ordinarily be released only with your permission as indicated below. There are some times when the laws require us to use or share your information. For example: 1) when there is a serious threat to your or another's health and safety or to the public (including statements indicating harm or abuse of children or vulnerable adults); 2) when we are required to do so by lawsuits and other legal or court proceedings; 3) if a law enforcement official requires us to do so and 4) for workers' compensation and similar benefit programs. There are also some other rare situations further described in our notice of privacy practices.

Please authorize release of our report and communications to:

	Name	Address/Phone #/Fax
Report (s) to :	____________________	____________________
	____________________	____________________
	____________________	____________________

- I give this office permission to release any information obtained during my assessment or treatment that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.
- I understand that I am responsible for all charges, regardless of insurance coverage.
- I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the professional above. Medicare regulations may apply.
- I am aware that an agent of my insurance company, third-party payer, and this professional's insurance administrator may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I authorize payment directly to this professional. I authorize the use of this signature on all my insurance submissions.
- A photocopy of this assignment is to be considered as good as the original.
- This assignment will remain in effect until revoked by me in writing.
- In consideration of consent, I hereby release the source of the records from any and all liability arising there from.
- I have read and agree with the nature and purpose of this assessment and/or treatment. I have had an opportunity to clarify any questions and discuss any points of concern before signing.

Name (printed): ____________________ Witness: ____________________

Signature: ____________________ Date: ____________________

Signature of Authorized Person (if applicable): ____________________ Relationship: ____________________