Comprehensive Neuropsychological Services
Phone (518) 458-2314 Fax (518) 446-9960
www.TreatBrainInjury.com

Financial Form A-Patient Information

Date: ____________________

Name: ____

Address: ____

City: _____________________ **State:** _____ **Zip:** _________ **Phone:** ____________

SSN: ___________________________ **DOB:** _______________

Employer: _____________________________ **Occupation:** ________________________

Work Address: ____

_______________________________ **Work Phone:** _________________

Spouse's Name: ______________________________ **Spouse's Phone:** ______________

Emergency Contact: ____

Relationship: ____________________________ **Phone:** ______________________

Primary Care Physician: ____

Address: ____________________________________ **Phone:** __________________

Attorney: ____ **Phone:** __________________

Address: ____

Who Referred You? ____

If you are not legally responsible for payment of your own bills, please give the name and contact information of the legally responsible party (ie: parent or legal guardian, POA, Trust Attorney, etc.)

Name: ____ **Phone:** ____________________

Address: ____

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Financial Form B-Insurance Information

Primary Insurance Carrier

Name: ____

Address: ____

ID/Claim #: ___________________ **Group#:** ___________ **Phone:** ______________

Secondary Insurance Carrier

Name: ____

Address: ____

ID/Claim #: ___________________ **Group#:** ___________ **Phone:** ______________

The information provided above is true and complete to the best of my knowledge.

____________________________________ ________________
Signature of Patient/Responsible Party **Date**

Assignment of Benefits

Financial Responsibility I understand that all professional services rendered are charged to the patient and are due at the time of services unless other arrangements have been made in advance with Comprehensive Neuropsychological Services(here in referred to as CNS). It is my responsibility to inform CNS of any insurance changes that may affect my benefits. I understand that I am responsible for any amount not covered by insurance.

Assignment of Benefits I hereby assign all insurance benefits directly to Comprehensive Neuropsychological Services. I hereby authorize my insurance carrier(s), to issue payment directly to CNS. I understand and agree that this Assignment of Benefits will remain in effect for the duration of my evaluation/treatment with CNS, or until such time that I revoke my authorization I writing.

Authorization to Release Information I authorize the release of any medical, psychological, or other information to my Insurance Carrier(s) or any other authorized entity necessary to determine medical insurance benefits, To receive benefits payable for services rendered, or for authorization to approve services. I understand that a copy of this assignment may be sent to my Insurance carrier(s) if request and the original will remain on file at CNS.

____________________________________ ________________
Signature of Patient/Responsible Party Date