Volusia Neuropsychology & Behavioral Health
REGISTRATION FORM

DATE OF APPOINTMENT:			
Please have your insurance card(s) and identification available to be photocopied			
PATIENT INFORMATION			
Patient's Name:			Marital Status (circle one): Single / Mar / Div / Sep / Wid / Par
Social Security No.:	Birth date: / /	Age:	Sex: ☐ M ☐ F
Street Address:			
P.O. Box:	City:	State:	ZIP Code:
Home Phone No.: ( )	Cell Phone No.: ( )	Work Phone No.: ( )	Other Phone No.: ( )
Occupation:	Employer:	Employer Phone No.: ( )	
Name of Primary Care Physician:	Phone No.:		
Date of Injury/Onset of Illness:	Motor Vehicle Accident?: ☐ Yes ☐ No		
Are you using an attorney for this incident? ☐ Yes ☐ No	If yes, please complete below:		
Attorney:	Phone No.: ( )		
Address:			
INSURANCE INFORMATION			
Person Responsible for bill:	Birth date: / /	Address (if different from patient):	Phone No.: ( )
Name of **PRIMARY** insurance:	ID/Policy No.:	Group No.: (if indicated on card)	
Name of **SECONDARY** insurance:	ID/Policy No.:	Group No.: (if indicated on card)	
IN CASE OF EMERGENCY			
Name of local friend/relative or spouse:	Relationship to Patient:	Home Phone No.: ( )	Cell or Work No.: ( )

I hereby acknowledge that I have received the Notice of Privacy Practices in accordance with HIPPA and that I agree to all the provisions therein. The above information is true to the best of my knowledge. Volusia Neuropsychology & Behavioral Health Inc may use my patient information as needed to submit billing(s) to my insurance company, attorney or other designated entity.

_____ _____

Patient/Guardian Signature Date

Volusia Neuropsychology & Behavioral Health

512 Canal St

New Smyrna Beach Fl 32168

Phone # 386-423-0442 **Fax # 386-423-0402**

CONSENT FOR PSYCHOLOGY/NEUROPSYCHOLOGICAL EVALUATION AND TREATMENT

I understand that the purpose of this evaluation is to provide information to my physician, health care provider, or other source who has requested the evaluation in order to assist in the diagnoses and/or treatment of any medical or psychological condition. the material from the interview and psychological/neurological testing will result in the generation of a report that will provide information related to diagnoses and/or treatment. The report generated by Dr. Merilson, Dr. Parker, Dr. Barnett, Dr. Meth, Dr. Bailey, or Sharon Crane will be sent to my physician , health care provider, or other identified source and Dr. Merilson, Dr. Parker, Dr. Barnett, Dr. Meth, Dr. Bailey or Sharon Crane may discuss results with them. If desired by me or my referring provider Dr. Merilson, Dr. Parker, Dr. Barnett, Dr. Meth, Dr. Bailey or Sharon Crane will also discuss the results with me or any others which I so designate by signing a release of information allowing Dr. Merilson, Dr. Parker, Dr. Barnett, Dr. Meth, Dr. Bailey or Sharon Crane to do so. If this evaluation and/or treatment is being covered or partially covered by my insurance, Dr. Merilson, Dr. Parker, Dr. Barnett, Dr. Meth, Dr. Bailey or Sharon Crane may be required to provide the insurance company with the records as well.

I agree to cooperate to the best of my ability and understand that although I am expected to give honest and accurate answers I am free to refuse to answer and question i choose to or terminate the evaluating at any time I desire. i also understand that i may choose to terminate psychological treatment at any time.

the terms of the evaluation and/or treatment and any potential limits to confidentiality have been reviewed and understood and agreed to by me.

_____ _____

Patients Signature Date

_____

Patients Name

Volusia Neuropsychology & Behavioral Health
512 Canal St
New Smyrna Beach, FL 32168
Phone #: 386-423-0442 Fax #: 386-423-0402

Financial Policy/Assignment of Benefits

Patient's Name: _____ ***Date of Birth:*** _____

As a patient, it is your responsibility to familiarize yourself with the terms of your health care plan. Your insurance policy is a contract between you and your insurance company. We will make every attempt to collect payment from your insurance company. Payment for services rendered by any doctor's office or facility is based on "medical necessity". This is determined by your insurance company therefore; our office cannot guarantee that the services performed will be paid. We will make all effort to obtain appropriate authorization and pre-certification for services. However, you are ultimately financially responsible for all or part of services provided by our office not covered by your insurance company. **Your deductible and co-payments are amounts determined by your insurance coverage and you are required to pay these deductibles and co-payments at the time of service.**

I hereby instruct and direct the following insurance company(s)

To pay by check, which should be made payable and mailed to:

Volusia Neuropsychology & Behavioral Health, Inc.
512 Canal St
New Smyrna Beach, FL 32168

Payable for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I agree to pay, in a timely manner, any balance of said professional service charges over and above any insurance payments.

A photocopy or facsimile of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Volusia Neuropsychology & Behavioral Health, Inc. to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ _____
Patient Signature Date

_____
Policyholder Signature (if other than patient)

Volusia Neuropsychology & Behavioral Health
512 Canal St New Smyrna Beach Fl 32168
phone 386-423-0042 fax 386-423-0402

AUTHORIZATION TO RECEIVE AND/OR RELEASE INFORMATION

Patient Name_____ DOB:_____

I hereby authorize the name(s) or organizations written below to release verbally or in writing the use or disclosure of my Personal Health Information (PHI). I understand that these records are privileged information and will not be further discussed without specific written consent of the person to whom it pertains, or otherwise permitted by law.

I voluntarily authorize Lisa M. Merilson, Psy.D, Julie L. Parker, Psy.D, Christine Bailey Ph.D, Alexa Barnett Psy.D, Michael B. Meth, Psy. D and or Sharon L. Crane, LMHC of Volusia Neuropsychology & Behavioral Health to receive and/or release my PHI.

Name(s)/ Organization to receive and/or release my PHI: Phone # and/or Fax #

_____ _____

_____ _____

_____ _____

Disclosure may include the following verbal or written information (Check all that apply)

_____All treatment records _____ Lab/Diagnostic testing results _____History & Physical

_____Psychiatric treatment records _____Medication records _____School information

_____Other (please specify)_____

Expiration: I understand that this authorization shall remain in effect for 12 months from the date of signature, unless otherwise revoked by me in writing prior to that time.

Revoke Authorization: I understand that I have the right to revoke this authorization, in writing, at anytime by sending written notification to the office of VN&BH. I further understand that the revocation of the Authorization in not effective to the extent that action has been taken in the reliance on the authorization.

Redisclosure: I understand that the information that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information may no longer be protected by the HIPPAA Privacy Policy.

I may request a copy of this authorization for my records. I certify that all my questions were answered to my satisfaction and that I understand this Authorization form and all its concerns.

_____ _____

Signature of patient , Parent, Guardian or Representative Date

Volusia Neuropsychology & Behavioral Health

512 Canal St

New Smyrna Beach Fl 32168

Phone # 386-423-0442 **Fax # 386-423-0402**

Patient Name_____Date_____

Name of Medication	Dosage