

**PATIENT REGISTRATION**

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ SSN: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_ Referred by: \_\_\_\_\_

Were you injured while working? (Workers' Comp)  NO  YES-->Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

Accident?  NO  YES-->Motor Vehicle?  YES  Other \_\_\_\_\_ Date of Accident \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you represented by an attorney?  NO  YES-->Attorney Name \_\_\_\_\_

Have you been treated before for these symptoms?  YES  NO Are you here on an emergency basis?  YES  NO

Are you covered by insurance health plan(s)?  YES  NO If YES, we need to make a copy of your insurance card(s).

Primary Ins. \_\_\_\_\_ Secondary Ins. \_\_\_\_\_

**Vocational Status:**

- full-time student Education: \_\_\_\_\_ Years Completed Degree: \_\_\_\_\_
- part-time student
- homemaker Handedness:  right  left  ambidextrous
- retired
- full-time employed Occupation: \_\_\_\_\_
- part-time employed Employer: \_\_\_\_\_
- limited employment Work Phone: \_\_\_\_\_
- unemployed
- disabled Marital Status:  Single  Separated  Divorced  Married  Widowed
- other \_\_\_\_\_

Medication	Dosage (mg)	# per day	Medication	Dosage (mg)	# per day
1)			4)		
2)			5)		
3)			6)		

Responsible Party, if other than patient: (who is responsible for payment of all costs incurred)

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ SSN: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Responsible party's relationship to patient:  Spouse  Child  Parent Other \_\_\_\_\_

**Note: Fees are posted at the receptionist's window.**

## Neuropsychological Services of Virginia, Inc.

**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 Neuropsychological Services of Virginia, Inc. (hereinafter "NSV") all charges incurred for services rendered to the Responsible Party. The Responsible Party understands that NSV will process the paperwork to complete insurance claim(s) but only as a courtesy to the Responsible Party, and the Responsible Party authorizes NSV 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 NSV. **It is, however, understood and agreed that the Responsible Party is responsible for all monies due and owing for services rendered by NSV 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. It is further agreed by the Responsible Party, that in the event any monies received by NSV from the insurance carrier which are at any time after their receipt withdrawn from NSV by the insurance carrier, the Responsible Party will be responsible for those monies then due and owing, and waives any defense for payment the Responsible Party may have against NSV. In the event this account is turned over to an attorney for collection, the Responsible Party hereby agrees to pay all costs of collection including, but not limited to, court costs and 33 1/3% 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 NSV.

A minimum of 48 hours' notice is required for cancellation of appointments. If this notice is not received, the Responsible Party may be charged for the full amount of time which was reserved for the appointment at the rates posted in the office of NSV. This may include legal fees for the time associated with subpoenas, depositions, and other court-related activities. Insurance will not be billed for missed/canceled appointments. Your copay is expected at the time of service. We will file the Responsible Party's initial insurance claim(s) and provide documentation necessary for insurance reimbursement. We do not, however, guarantee that each service will be covered or what percentage will be covered. The Responsible Party may incur extra charges for refiling of insurance claims.

In the event that the Patient's/Responsible Party's insurance does not cover our services (or any portion thereof), NSV will work with the Responsible Party regarding payment (e.g., setting up a payment plan). NSV expects full payment within thirty (30) days of the date of service. **The Responsible Party hereby agrees that accounts not paid within thirty (30) days will be charged a late fee of \$15.00 and will accrue interest at the rate of 1.5% per month (18% A.P.R. - a minimum of \$1.00 will apply).** 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, NSV may not be able to seek payment from third parties, and NSV cannot wait on the outcome of pending litigation for payments. NSV does not accept contingency fee arrangements, as that is prohibited in Dr. Peck's profession. If there is any remaining balance(s) due at the time of settlement, the Responsible Party hereby authorizes their attorney to clear the Responsible Party's outstanding accounts. In the event the Responsible Party has "**medpay**" available and health insurance, NSV 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 directly to NSV prior to claimant receiving such funds.

Responding to Forensic/Medical Legal requests, conferences and telephone calls with attorneys involve additional time and record keeping. The Responsible Party is responsible for all direct costs and expenses associated with NSV and its attorney responding to discovery requests (including depositions and subpoena duces tecum time and labor costs) and with conferences including, but not limited to court appearances, preparation of reports, photocopying, faxes, long-distance telephone calls, out of office travel, overnight delivery and courier services. These expenses are billed to the Responsible Party and to the Patient's/Responsible Party's Attorney. The Responsible party, however, remains responsible for payment of these charges if not paid in full within sixty (60) days.

NOTE: Testing includes time for (1) administering and (2) scoring the tests, (3) preparing the report, and (4) discussion of the results (feedback). In nonforensic/nonmedical-legal cases, this will typically add 1-4 hours to the actual testing time. Forensic/medical-legal cases typically require even more time and may include record review and consultation(s) with attorney(s), etc. In certain cases (such as, but not limited to, medical-legal cases), a more comprehensive and time-consuming assessment may be needed than what may be approved under your insurance plan [for example, when an insurance plan covers up to 3 hours of testing/report preparation but Dr. Peck feels that your case requires additional hours of testing/record review/report preparation/etc]. The responsible party as noted below accepts responsibility for these charges.

If you have any questions, please speak with our Secretary, our Office Manager, or **Dr. Peck**. Your signature indicates that you have read the above and agree to the terms contained therein. These agreements are irrevocable.

Patient Signature: \_\_\_\_\_ Responsible Party: \_\_\_\_\_  
Date: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature (if patient is a minor or unable to sign\*\*): \_\_\_\_\_ Date: \_\_\_\_\_

\*\***If patient is a minor, are you her/his legal guardian?** [ ]YES [ ]NO If **NO**, please see Dr. Peck regarding this matter.