Oakland Neuropsychology Center
4190 Telegraph Rd Ste 2700
Bloomfield Hills, MI 48302

PATIENT INFORMATION

Last Name_______________ First_______________ MI_____ Marital Status_______

Street Address_______________ City_______________ State_______ Zip_______

Home Phone_______________ Cell Phone_______________ Ok to leave message? Yes ☐ No ☐

Date of Birth_______________ Age_______ Sex_______ Soc Sec Num_______________

Email Address_______________ Referred By_______________

Employer_______________ Work Phone_______________

GUARANTOR INFORMATION

WHOMEVER BRINGS IN MINOR CHILD MUST COMPLETE THIS SECTION

Last Name_______________ First_______________ MI_____ Marital Status_______

Street Address_______________ City_______________ State_______ Zip_______

Home Phone_______________ Cell Phone_______________ Ok to leave message? Yes ☐ No ☐

Date of Birth_______________ Age_______ Sex_______ Soc Sec Num_______________

Email Address_______________

POLICYHOLDER INFORMATION

Last Name_______________ First_______________ MI_____ Marital Status_______

Street Address_______________ City_______________ State_______ Zip_______

Home Phone_______________ Cell Phone_______________ Ok to leave message? Yes ☐ No ☐

Date of Birth_______________ Age_______ Sex_______ Soc Sec Num_______________

	PRIMARY	SECONDARY	OTHER
INS COMPANY NAME			
POLICY HOLDER NAME			
POLICY NUMBER			
RELATIONSHIP TO PATIENT			

All signatures contained herein apply to services rendered at:

OAKLAND NEUROPSYCHOLOGY CENTER

Informed Consent for Treatment:

I hereby agree and consent to participate in treatment/testing services provided by my provider. If the patient is under the age of 18 or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and or legally authorized to initiate and consent to treatment on behalf of this individual.

X Signature____Date______________________________

Relationship to patient (if applicable)____

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, employees 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 understand that I am financially responsible for all charges. Provider will be paid in full at the time of service unless other arrangements have been made.
4. 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.
5. I understand that Oakland Neuropsychology Center is an OUT OF NETWORK provider and is filing any claims as a courtesy only.

X Patient Name____ Date______________________________

X **Patient OR Guarantor Signature** (if patient is a minor)____

HIPAA Privacy Notice Acknowledgement:

I understand that I have been given an opportunity to read a copy of my provider's Notice of Privacy Practices. I understand that if I have any questions, that I can direct my question to my provider of service.

✓ Signature____ Date______________________________