

Northwest Neuropsychology Incorporated and Advanced Biofeedback Center Registration Form

Please print

Date _____ Home phone _____ - _____ Cell phone _____ - _____ E-mail _____ @ _____

Patient _____
Last Name First Name Middle Name

Responsible party (if patient is a minor) _____

Home Street Address _____

City _____ State _____ Zip Code + 4 _____ - _____

Male Female Age _____ Date of Birth ____ / ____ / _____ Single Married Widowed Separated Divorced

Patient Employed By _____

Business Address _____

Occupation _____ Business Phone _____ - _____

Patient's Social Security Number _____

Spouse (or Responsible Party) Name _____ Date of Birth ____ / ____ / _____

Spouse/Responsible Party Business Name and Address _____

Spouse/Responsible Party Occupation _____ Business Phone _____ - _____

Spouse/Responsible Party Social Security Number _____

Who is Responsible for the Patient's Account? _____ Relationship to Patient _____

Do You Have Medical Insurance? No Yes If Yes, Please Complete the Following:

Name of Primary Insurer _____

Contract No. _____ Group No. _____ Subscriber No. _____

Address to Mail Primary Claim _____

Name of Secondary Insurer (if any) _____

Contract No. _____ Group No. _____ Subscriber No. _____

Address to Mail Secondary Claim _____

Medicare Medicaid Claim ID# _____

Religious Affiliation _____

In Case of Emergency, Whom Should Be Notified? _____ Phone Number(s) _____ - _____

How Did You Learn of Our Practice? _____

Assignment and Release

I, the undersigned, have insurance coverage with _____
Name of Insurance Company or Companies

and assign to **Dr. Alexander Adam Eschbach, Ph.D.** all medical benefits, if any, offered to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of all benefits. I authorize the use of this signature on all of my insurance submissions.

Signature of Insurance Patient / Responsible Party / Guardian Date ____ / ____ / _____

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Dr. Alexander Adam Eschbach, Ph.D.** for any services furnished me by that health care provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 Form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Insurance Patient / Responsible Party / Guardian Date ____ / ____ / _____