29 Ravenscroft Dr. • Second Floor
Asheville, North Carolina 28801

Ph (828) 545-7776
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Registration Form

Instructions: Please complete all sections. Write "same" if information is the same as previous section.

Patient Name: ____________________ Patient SSN: ____________________

Address: ____________________ Date of Birth: ____________________

____

Home Phone: ____________________ Work Phone: ____________________

Referring Physician: ____________________

Also send a report to: ____________________

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Insurance Information

Responsible Party: ____________________ Relationship: ____________________

Employer: ____________________

Primary Insurance: ____________________

Address: ____________________ Phone: ____________________

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Name of Insured: ____________________ Insured DOB: ____________________

Insured SS#: ____________________ Employer: ____________________

Policy #: ____________________ Group#: ____________________

Pre-authorization required: Y N Pre-auth Phone: ____________________

Pre-authorization number: ____________________

Secondary Insurance: ____________________

Address: ____________________ Phone: ____________________

____

Name of Insured: ____________________ Insured DOB: ____________________

Insured SS#: ____________________ Employer: ____________________

Policy #: ____________________ Group#: ____________________

Pre-authorization required: Y N Pre-auth Phone: ____________________

Pre-authorization number: ____________________

Please read and sign the back of this form.

Clinic Policies

The service today will be billed by the hour. In accordance with CMS standards of practice, billing for neuropsychological assessment will include time to administer tests, score tests, interpret tests/interview/records, prepare the report, and provide necessary feedback to the patient/family. For non-forensic cases, this will typically add 1-3 hours to the actual testing time. Forensic/medicolegal cases typically require more time and may include record review and consultation(s) with attorney(s), etc.

You are required to pay all co-pays and coinsurance amounts. Your insurance policy is a contract between you and your insurance company. You are ultimately responsible for any balance not covered by your insurance policy. As a courtesy, we will bill your insurance for you. We will make every effort to ensure that claims are complete and accurate when submitted; however, follow up on your insurance claim is your responsibility. **If your insurance does not reimburse us within 60 days, you will become responsible for the balance**; you will be refunded any amount subsequently received from your insurance company.

In certain circumstances, we will make arrangements for a payment plan. However, it is generally unethical and/or illegal for us to waive your co-payment and/or deductible.

For Medicare patients: We are a participating provider and, therefore, accept assignment. We will also bill any secondary insurance policies; however, you will be responsible for any balance remaining after all policies have been billed.

For patients with a pending Workman's Compensation claim, personal injury claim, or other litigation: We will bill all relevant insurance carriers. In the event reimbursement is not received within 60 days, you will be responsible for any remaining balance. Please note, contingency fee arrangements are prohibited by our professional ethical standards.

We are pleased you have chosen to come to our clinic. Please do not hesitate to request clarification of any clinic policies or ask any other questions regarding your service. We are happy to respond to any concerns.

Guarantee of Payment and Assignment of Insurance Benefits

For value received, the undersigned guarantor (hereinafter "the Undersigned") and/or patient (hereinafter "the Patient") promises to pay to Mountain Memory Assessment (hereinafter "Provider") all charges incurred for services rendered to the Patient. The Undersigned understands that Provider will process the paperwork to complete insurance claim(s) as a courtesy to the Undersigned, and the Undersigned and/or the Patient authorize Provider to release any and all medical information necessary to complete insurance claim(s) and assigns any payment due and owing under the insurance contract to said Provider. It is, however, understood and agreed that the Undersigned is responsible for all charges due and owing for services rendered by Provider in the event insurance does not pay for these services. It is acknowledged that completing and following-up of any insurance claims is ultimately the responsibility of the Undersigned. It is further agreed by the Undersigned that in the event any payments received by Provider from the insurance carrier are at any time after their receipt withdrawn from Provider by the insurance carrier, the Undersigned will be responsible for those charges then due and owing, and waives any defense for payment the Undersigned may have against Provider. In the event this account is turned over to an attorney or other agent for collection, the Undersigned hereby agrees to pay all costs of collection, not limited to court costs but including reasonable attorney's fees. The Undersigned and/or Patient authorize use of this form of all insurance claim submissions. Your signature indicates you have read the above and agree to the terms contained therein. This agreement is irrevocable.

______________________________	______________________________
Signature of patient or guarantor	Date
______________________________	______________________________
Relationship to patient	Witness