**Institute for Applied Neuroscience**

Ed Hamlin, Ph.D. BCN Mary Ammerman, Psy.D. BCN Steven Gold, Ph.D.

Sarah Mims, LCSW Eric Ralston, LPC

Pat Hamlin, LPCA Mary Grace Bigelow, LPCA Illysa Hamlin, BA Jordan Hamlin, BA

PATIENT INFORMATION

Name (Last, First, MI):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address (Street, City, State, Zip): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender Assigned at Birth: MALE/FEMALE Current Gender Identity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the patient a minor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Doctor (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE

**Please provide your (or the responsible party's) insurance card to the front to be copied, or sign below for self-pay.**

RESPONSIBLE PARTY FOR BILLING (if not self)

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M / F

EMERGENCY CONTACT INFORMATION

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SELF PAY AGREEMENT

I have no insurance coverage or am not using insurance, therefore, I understand that I am responsible for payment of services rendered to myself or my dependents at the time of service.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Read Each of the following carefully and sign below

**Insurance Authorization and Assignment**

I hereby authorize the Institute for Applied Neuroscience to release any information necessary to process insurance claims and request payment of benefits to be made to the Institute for Applied Neuroscience for services rendered to myself or my dependents. I understand that I am responsible at the time of service for paying any required co-payment and/or deductible.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization and Consent for Treatment**

I hereby grant my authorization and consent to treatment and procedures deemed appropriate and certify that no guarantee or assurance has been made as to the results which may be obtained. I also give my consent for my personal health information to be shared with any other clinicians within the Institute for Applied Neuroscience for treatment purposes only.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Records**

While patients are entitled to access their medical records, requests are contingent upon the discretion of the patient's clinician(s) for approval of the medical record request and therefore may take several days to process.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT FINANCIAL AGREEMENT

The management of mental health benefits has become very complex and time consuming. We try to be accurate when informing you of your benefits, but as the insurance companies clearly state, benefit information is not a guarantee of payment. We, therefore, cannot be certain of your account balance until after we received payment and ask that you affirm the following:

* I am responsible for knowing whether my insurance covers these services and the provider I am seeing. (There are customer service numbers on your insurance card to call for clarification.)
* Co-payments are due at the time of service. This is the total of what the insurance company does not pay. If co-payments are not made, continued service may not be possible.
* Insurance policies are contracts between you and your insurance company. I.A.N. files claims as a courtesy and will attempt to help with any problems, but it is my responsibility to resolve issues beyond I.A.N.'s control. If my insurance fails to provide payment within a reasonable timeframe, I will become responsible for the full payment.
* I.A.N. will not file secondary insurance if the secondary policy is Medicare. If you have Medicare as a secondary insurance, you will need to file it yourself. The secondary benefit amount will need to be covered by you otherwise.
* If my provider is not covered by my insurance company, full payment is due when services are provided.
* There will be charges for missed appointments and late cancellations, considered to be late if cancelled less than 24 hours in advance.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COPY OF PRIVACY PRACTICES

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print name), have been offered a copy of the Institute for Applied Neuroscience's Notice of Privacy Practices.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_