Neurofeedback Advantage

Reach Your Goals with Neurofeedback

NEW PATIENT REGISTRATION

Patient name ______________________________ DOB__________ Age ________

Home Address ______________________________ Phone(H) ______________

Occupation ______________________________ Phone(W)______________

If Student: School ______________________________ Phone(C)______________

Email ______________________________ Best way to contact you? ______________

Referral source: ______________________________

Party responsible for payment:

Responsible Party: ______________________________ DOB______________

Home Address: ______________________________

Phone (H) ______________________ Occupation: ______________________

Phone (C) ______________________ Phone (W) ______________________

Spouse's Name ______________________________

Address, if different ______________________________

Insurance Billing: To focus my work on the Clinical and Neurofeedback issues important to your care, I elected to leave all insurance panels several years ago. I based my decision on my commitment to provide you with the best possible treatment, free of managed care intrusion, and insurance restrictions. Please note that most Massachusetts based insurances do not cover Neurofeedback. I provide my services based on private pay at the time services are rendered.

Upon request, I will be happy to provide you with a receipt that you can submit to your insurance carrier for possible reimbursement. You are responsible to determine any insurance coverage. You are responsible for all charges, whether covered by insurance or not.

Cancellation Policy: I require 24 hours notice to cancel any scheduled appointment. If you cancel an appointment with less than 24 hours you will be charged for the missed appointment. You are responsible to pay this at your next appointment.

I have read and understand the above stated policies.

Signature of Parent/Responsible Party (required):

______________________________ Date______________

You have my permission to thank the referral source: Y______________ N ______________