



JEFFERSON NEUROBEHAVIORAL GROUP

CLINICAL PSYCHOLOGY • NEUROPSYCHOLOGY • BEHAVIORAL MEDICINE
RESEARCH - ASSESSMENT - INTERVENTION - FORENSIC CONSULTATION - REHABILITATION

Patient Name _____

Date _____

Patient's Primary Insurance Information

Name of Insurance Company (*please provide copy of card*) _____

Subscriber's Name _____ Subscriber's SSN _____

Address (*if different from patient*) _____

City _____ State _____ Zip Code _____

Subscriber's Number _____ Subscriber's Date of Birth _____

Home Phone _____ Work Phone _____

Patient's relationship to Insured (*check one*): [] Self [] Spouse [] Child [] Other

Patient's Secondary Insurance Information

Name of Insurance Company (*please provide copy of card*) _____

Subscriber's Name _____

Address (*if different from patient*) _____

City _____ State _____ Zip Code _____

Subscriber's Number _____ Group Number _____

Home Phone _____ Work Phone _____

Patient's relationship to Insured (*check one*): [] Self [] Spouse [] Child [] Other

24-HOUR CANCELLATION OF AN APPOINTMENT IS REQUIRED OR YOU WILL BE CHARGED IN FULL FOR YOUR SCHEDULED AMOUNT OF TIME. This charge will be billed to you. Your insurance company is not responsible for missed appointments.

If we are billing your insurance, you are responsible for the cost of services should your insurance company refuse payment. Finance charges of 1% will be assessed on balances over 90 days.

Assignment of Insurance Benefits

I authorize the release of any information relating to all claims for benefits submitted on behalf of myself and / or dependents. I further expressly agree and acknowledge that my signature on this account authorizes **my provider** to submit claims for benefits, for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and /or dependents. I agree that I will be bound by this signature (below) as if I had personally signed the particular claim.

I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by, and paid to **my provider**, will be credited to my account, in accordance with the above said assignment. **I understand that I will pay for any visits when I fail to provide a 24-hour notice of cancellation.**

Authorized Signature (*Patient, Parent or Legal Guardian*)

Date

Witness

Date