Metrowest 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: In order to provide you with the highest quality of service, Metrowest Neurofeedback is not contracted with insurance companies. We apologize for any inconvenience this may cause and do realize you have a choice of mental health providers. This decision is based on our commitment to provide you with the best treatment possible, free of managed care and insurance restrictions. All services are provided on a private-pay basis only. Payment is due when services are rendered. For your convenience, we accept checks or credit cards. We will provide itemized receipts on request that may be submitted to your insurance carrier for possible reimbursement. It is your responsibility to determine any insurance coverage. **Patients (or the responsible parties) are responsible for all charges, whether covered by insurance or not.**

CANCELLATION POLICY: Cancellations for scheduled appointments must be received 24 hours in advance. **Missed (or cancelled) appointments that do not follow this policy will be charged a missed appointment fee (regular appointment fee).** Failure to provide notice means time lost by your clinician, and prevents another patient from using that time**.** Insurance companies do not pay for missed appointments. The patient/responsible party is responsible for this charge, which is to be paid at the next session.

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 _____