THE NEUROPSYCHOLOGY CENTER
6000 SHAKERAG HILL, SUITE 216
PEACHTREE CITY, GA 30269

Welcome. It is a pleasure to serve you. Please take a moment to complete the following:

PATIENT INFORMATION

DATE _____

NAME _____

ADDRESS _____

_____

HOME PHONE _____

DATE OF BIRTH _____ SOCIAL SECURITY _____

.....

CONTACT PERSON ☐ PARENT ☐ RELATIVE ☐ OTHER

NAME _____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? _____

PEDIATRICIAN _____

CITY OF PRACTICE _____ TELEPHONE _____

INSURANCE INFORMATION

Primary Insurance: _____

Name of Insured: _____

Insurance Telephone: _____

Policy Number: _____

Group Number:

_____

.....

Secondary Insurance: _____

Insurance Telephone: _____

Policy Number: _____

SIGNATURE ON FILE AND AUTHORIZATION

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes.

I understand that I am personally responsible for all fees charged by The Neuropsychology Center for services. I understand that fees are payable upon receipt of services unless prior arrangements have been made.

I authorize the Neuropsychology Center to perform any necessary services that I may need during diagnosis and treatment with informed consent.

I authorize payment of Insurance/Medicare benefits to the undersigned Neuropsychologist for services rendered, Alfonso Martinez, Ph.D. of The Neuropsychology Center, LLC.

I authorize The Neuropsychology Center, to release to my insurance company and/or the Health Care Financing Administration and its agents, any information needed to determine these benefits for related services.

_____ _____

Parent / Guardian Signature **Date**

Thank you for providing this necessary information so that we may more effectively serve you.