Neuropsychiatric Institute
(813) 636-8811

PATIENT INFORMATION

4107 W Spruce St Ste100
Tampa, FL 33607-2346

*Date:*_____ *Account Number:*_____

*Last Name:*_____ *Phone #1:*_____ ☐*Home* ☐*Work* ☐*Cell*

*First:*_____ *MI:*_____ *Phone #2:*_____ ☐*Home* ☐*Work* ☐*Cell*

*Address:*_____ *Email:*_____

_____ *Date of Birth:*_____ *SS#:*_____

*City:*_____ *Marital Status: (S)ingle (M)arried (O)ther:*_____

*ST:*_____ *Zip:*_____ *Sex:*_____

*Employer/School:*_____
☐*Full Time Student* ☐*Part Time Student*

*Emergency Contact:*_____
*Emergency Phone:*_____

If patient is a minor or someone other than patient is responsible for payment, please complete the following:

*Name:*_____ *Relation to Patient:*_____

*Address:*_____ *DOB:*_____ *SS#:*_____

*City:*_____ *Employer:*_____

*ST:*_____ *Zip:*_____ *Sex:*_____ *Phone:*_____ *Ext:*_____

Insurance #1:	*Insurance #2:*
_____	_____
*Address:*_____	*Address:*_____
*City,ST,Zip:*_____	*City,ST,Zip:*_____
*ID/CLM#:*_____	*ID/CLM#:*_____
*GRP/PLCY#:*_____	*GRP/PLCY#:*_____
*Insured and DOB:*_____	*Insured and DOB:*_____

RELEASE OF RECORDS:
I authorize the release of general medical, as well as psychological/psychiatric, substance abuse, or other information pertinent to my treatment, to any insurance company, adjuster, case manager, or attorney as may be necessary to process health insurance claims, or to facilitate collection of any balance due for services rendered. I understand that this authorization releases Neuropsychiatric Institute LLC from all legal liability that may arise from the release of the information.

ASSIGNMENT OF BENEFITS/PROCEEDS;FINANCIAL RESPONSIBILITY:
I hereby authorize and direct any Payor on my behalf (including health insurance, disability insurance, worker's compensation, liability insurance, Medicare, Medicaid, a government entity, or attorney) to pay any medical and/or government benefits, or from the proceeds of any settlement, judgment or verdict, due to me directly to Neuropsychiatric Institute LLC (Provider) for services rendered, both by reason of illness or injury, and by reason of any other bills that are due Provider. This is to act as an assignment of my rights and benefits to the full extent allowable under the law and/or to the extent I am obligated to pay Provider for services rendered. I understand that I am and remain personally responsible for deductibles, co-payments, and any professional services not covered and/or not paid by Payor(s). If it becomes necessary to turn my account over for collection, I will be responsible for collection and/or attorney fees. I also understand that Provider may perform a "Trace" or search to verify my name, social security number and/or mailing address.

- *A fee will be assessed on returned checks ($20 fee or the amount charged by Provider's bank, whichever is higher).*
- *A fee may be charged for appointment not kept, if Provider does not receive notification at least 24 hours prior to scheduled appointment.*

A photocopy or digital copy of this document shall be considered to be as valid and enforceable as the original.

*Signature:*_____ *Witness(Office):*_____
Insured/Responsible Party

The doctors and staff at Neuropsychiatric Institute would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visits as convenient as possible.

FINANCIAL POLICY

- *It is your responsibility to inform our office of any address or telephone number changes.*
- *Your account is to be kept current - accordingly, all self-payor insurance co-payments, co-insurances and deductibles will be collected at the time of service. Payable by cash, check, Visa, MasterCard, Discover or American Express.*
- *If you do not have your payment(s), your appointment may be rescheduled.*
- *You may be asked to schedule another appointment for issues other than the reason for your original appointment.*
- *A returned check will result in all future payments being required in the form of cash or credit card.*
- *A fee of $50 may be charged for appointment not kept without notification at least 24 hours prior to scheduled appointment.*
- *You will only be sent a statement if your balance exceeds $5 and you will only receive a refund if the credit amount is over $10. Refunds will be issued within 4-6 weeks from the date requested, if there are no pending insurance claims.*
- *There is a $50 charge for the completion of paperwork (ex: disability, FMLA, etc.).*
- *If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees.*
- *You will be billed $50 in the event that you miss an appointment or fail to cancel 24 hours prior to the scheduled appointment.*

IF YOU HAVE HEALTH INSURANCE COVERAGE:

*We will submit your claims, however **we must emphasize that as medical providers, our relationship is with you, not your insurance company**. Although we verify your benefits with your insurance company, we can only provide an estimate of your coverage based on the information given to us at the time of the inquiry.*

- *It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.*
- *Not all services are a covered benefit with all insurance plans.*
- *It is your responsibility to be aware of the service(s) being rendered, and whether your insurance policy covers those services.*
- *You are responsible for any non-covered charges not payable by your insurance policy.*
- *Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from the date services are rendered.*

*We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information please do not hesitate ask us. **We are here to help you**.*

I have read and understand the above Financial Policy and agree to meet all financial obligations.
(A photocopy or digital copy of this document shall be considered to be as valid and enforceable as the original.)

Patient Name (Please Print)	*Responsible Party Signature*	*Date*

4107 West Spruce Street, Suite 100, Tampa, Florida 33607 - (813) 636-8811 - Fax (813) 636-8855