Pinehurst Neuropsychology
Brain & Memory Clinic

PATIENT INFORMATION

Name: _____

Date of Birth: ____/____/____ Age: _____

Social Security Number: _____

Mailing Address: _____

_____

Employer/Occupation: _____

Home Phone: (____) _____ Email: _____

Cell Phone: (____) _____

We have a patient portal that will send you a link if you provide your email address.

Work Phone: (____) _____

Primary Care Doctor: _____

Pharmacy: _____

Optional:

Race: _____ Hispanic/Latino ☐ YES ☐ NO

Emergency Contact:

Full Name: _____

Mailing Address: _____

_____

Phone: (____) _____ Date of Birth: ____/____/____

Relationship to Patient: _____

If Emergency Contact will be responsible for bills, or if the patient is carried on the Emergency Contact's insurance it may be necessary to have the Social Security Number for this person.

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CONSENT FOR TREATMENT

I, _____
hereby seek and consent to take part in the neuropsychological treatment and authorize Pinehurst Neuropsychology to perform an initial interview, therapy and/or neuropsychological testing.

I understand that services may include face-to-face contact interviewing and providing therapy and/or testing services with a follow-up appointment to receive the results of testing. Services may also include the neuropsychologist's time required for the reading of records, consultations with professionals, scoring, interpreting the results, report writing and any other activities to support these services. I agree to help as much as I can by supplying full answers, making an honest effort and working as best as I can to make sure that the findings are accurate.

Further, I understand that evaluation and treatment will involve discussion of personal events in my and/or my families own history which, at times, can be discomforting and is at times very personal. I am aware that I may terminate my treatment at any time without consequence, but that I will remain responsible for payment for services that I have received.

Your signature below indicates that you have read the information in the Informed Consent to Treatment.

Signature of Patient: _____

Date: _____/_____/_____

Office Phone: 910-420-8041 | **Fax:** 910-420-8071 | **Address:** 45 Aviemore Drive, Pinehurst, NC 28374

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HIPAA ACKNOWLEDGMENT

Patient: _____

Date of Birth: _____/_____/_____

My signature below indicates that I have been given the chance to review a current copy of Pinehurst Neuropsychology's "Notice of Privacy Practices".

Within the Notice of Privacy Practices is a complete description of patient's privacy/confidentiality rights. These right include, but are not limited to, access to medical records and receiving an account of any disclosures made to other sources as required by law.

I understand that it is sometimes necessary to disclose patient's personal health information to assist in providing healthcare, to handle billing and payment, and to take care of any other health care operations. Under normal circumstances, there are generally no other uses and disclosures of this information unless I permit it. I do understand that sometimes the law may require the release of this information without my permission. (These situations are very unusual. One example would be if a patient threatened to hurt themselves or someone else.)

Signature of Patient: _____

Date: _____/_____/_____

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USE AND DISCLOSURE CONSENT

Patient: _____ Date of Birth: ____/____/____

I give permission for the following items to Pinehurst Neuropsychology by marking each:

_____ To use Protected Health Information within Pinehurst Neuropsychology for the purpose of my treatment.

_____ To disclose Protected Health Information as necessary to my insurance carrier. If this is not approved, I understand that my insurance will not be filed and I will be responsible for 100% of all charges.

_____ To share Protected Health Information with my Referring Physician.

_____ I understand that as part of Pinehurst Neuropsychology's treatment, payment, or healthcare operations it may become necessary to disclose my Protected Health Information to another entity (whom is bound to utilize all Privacy Laws) and I consent to such disclosure.

Please list, if any, person(s) whom we may discuss about your medical condition, diagnosis, and/or financial account:

Name: _____ Phone: (____) _____

Name: _____ Phone: (____) _____

I understand that this authorization can be revoked at any time by submitting a written request of revocation to Pinehurst Neuropsychology. We will then stop sharing your information; however, if we have already used or shard some of it, this cannot be changed.

I understand that if I refuse to sign this authorization, Pinehurst Neuropsychology may not be able to treat me.

Patient Signature: _____

Date: _____/_____/_____

Witness: _____

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