NORTHEAST NEUROPSYCHOLOGY LLC
BRAIN & BEHAVIORAL HEALTH PARTNERS

REGISTRATION

Cheshire Office: 609 West Johnson Ave, Suite 104 • Cheshire, CT 06410
Farmington Office: 231 Farmington Avenue • Farmington, CT 06032
Phone 203-272-8895 • Fax 203-272-8895 • www.NENEUROPSYCH.com

Date____________________ Home Phone (_____)________________ Cell Phone (_____)________________

PATIENT INFORMATION

(Please Print)

Name____
Last Name First Name Middle Initial

Address____

City ____ State __________________ZIP_________________

Email ____

Age _______ Birthdate ______________________

Sex: ❑M ❑F ❑non-binary ❑other

❑Married ❑Single ❑Widowed ❑Separated ❑Divorced ❑Partnered for __________years

Patient Employer or School ______________________________________ Occupation ________________________________

Employer or School Address ____________________________________ Employer or School Phone ______________________

Whom may we thank for referring you? ____

In case of emergency, who should be notified _________________________________Phone___________________________

ASSIGNMENT AND RELEASE

I certify that I, and or my dependent(s), have insurance coverage with __________________________/__________________________
(Name of primary Ins.) (Name of secondary Ins.)

and assign directly to Dr. ______________________________ and/or Northeast Neuropsychology all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above name insurance company(ies) and their agents for the purpose of obtaining payment for services determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ ____________________________________

Signature of Patient, Parent, Guardian, or Personal Representative Date

____

Please Print name of the Patient, Parent, Guardian, or Personal Representative