Memory & Psychological Services, Inc. & Jody Pickle, PhD, LLC
8180 Brecksville Road, Suite 115
Brecksville, OH 44141
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PATIENT REGISTRATION FORM Page 1 of 2

PLEASE USE INK AND FILL IN ALL SECTIONS COMPLETELY

First Name_____ MI_____ **Last Name**_____

Address_____

City_____ State_____ Zip Code_____

Home#_____ Cell#_____ Work#_____

SSN#_____ **DOB**_____ Age_____ Marital Status M S W D

Male_____ Female_____ Email_____

Referred by_____ Phone#_____ Date of next apt_____

Emergency Contact Name_____

Relationship to Patient_____ Phone#_____

If you would like statements for patient balances mailed to a different name and/or address, please provide that information below.

_____

Are you represented by an attorney or involved in litigation regarding this issue? Yes ( ) No ( )
If yes, name of attorney and phone number:

_____

Were you injured while working? (Workers' Compensation) Yes ( ) No ( ) If yes, date of injury_____

MCO_____ Claim#_____

INSURANCE INFORMATION
Current insurance card(s) and a picture ID must be presented at the first visit.
COPAYS ARE DUE AT TIME OF SERVICE
Please DO NOT complete this section for self-pay, court ordered, employer referred, or Workers' Compensation patients (see above).

Primary Insurance_____ ID#_____

Group#_____ Name of Insured_____

Secondary Insurance_____ ID#_____

Group #: _____ Name of Insured: _____

***** *PLEASE READ AND SIGN REVERSE SIDE* *****

PLEASE INITIAL BY EACH PARAGRAPH BELOW INDICATING YOU HAVE READ THE INFORMATION PROVIDED

_____FILING INSURANCE CLAIMS AND OBLIGATION OF PAYMENT: Insurance coverage is a contract between the patient/guarantor and their insurance company. It is your responsibility to determine if your insurance requires referrals, pre-authorization, or has visit limits. **All charges are ultimately the responsibility of the patient/guarantor.** Payment for co-pays, co-insurance, and/or deductibles is required at the time of service. There is a $50 fee for returned checks.

_____If the patient is covered by an insurance carrier with whom we participate, Memory & Psychological Services, Inc. (MPS) will file insurance claims as a courtesy, and will provide all documentation necessary for reimbursement. Although MPS makes every effort to confirm benefits and obtain pre-authorization for services, this is not a guarantee of payment. Many insurance carriers maintain a policy of reimbursement based on medical necessity, which is only determined after receipt and review of claims. Please contact your insurance company directly with questions regarding coverage and benefits.

_____Medical insurance cannot be used if the patient is seeking assessment for litigation purposes, or if the patient is seeking assessment solely for educational, competency, disability or placement purposes. In these cases, or if the patient is not covered by an insurance carrier with whom we participate, payment in full is required at the time of service.

_____BALANCES AND COLLECTION COSTS: Any remaining balance on a patient account, after an insurance carrier or third party payor has reimbursed their contracted amount, or all attempts to collect have been exhausted, are the responsibility of the patient/guarantor and are **due upon receipt** of an invoice or billing statement. Balances that have not been fully paid within 90 days will be referred to a collection agency. It is your responsibility to notify us of any change in address or other contact information.

_____CANCELLATIONS / NO SHOWS: This office requires at least 72 hours' notice if the patient is unable to keep an assessment appointment and at least 24 hours' notice if the patient is unable to keep a feedback or therapy appointment. Failure to provide this notice may result in a $50 fee. Insurance plans will not cover these fees. All late cancellation and no show fees must be paid prior to re-scheduling. Patients that consistently miss or late cancel appointments may not be re-scheduled.

_____**RESEARCH:** This office is involved in research and may collect information about you, your symptoms, the effectiveness of your treatment, or other variables related to your care. After all identifying information is removed, information may become part of a research initiative. This information is used to improve the services we offer and to contribute to the body of knowledge about effective treatment. You may choose to refuse to allow this information to be used for research by opting out below. Opting out will not affect your care, and there will be no penalty or repercussions to you if you choose to opt out.

ASSIGNMENT OF BENEFITS: The undersigned does direct and assign payment from any insurance coverage, workers' compensation, governmental agency, disability benefit, and assignment of proceeds from all settlements, judgments or verdicts in favor of the undersigned from third party liability claims in an amount equal to the full amount of charges incurred to MPS or Jody Pickle, PhD, LLC (JPLLC), or in a manner compliant with current law, including HIPAA. I further authorize MPS/JPLLC to release to my insurance company, attorney, and/or guarantor information regarding treatment, diagnosis, prognosis, and referrals, but only to the extent reasonably needed to process the insurance claim(s) or otherwise collect payment for services rendered.

PRIVACY AND USE OF PROTECTED INFORMATION: I, the undersigned, have reviewed and understand the Notice of Privacy Practices posted in the office waiting area and on the MPS website. I also understand that this organization has the right to change its Notice of Privacy Practices, and that I may contact MPS at any time to obtain a current copy. I consent that my Protected Health Information may be used in accordance with the Notice of Privacy Practices and that if I wish to request additional restrictions on the use or disclosure of my Protected Health Information, I must make such requests in writing to MPS/JPLLC.

ACKNOWLEDGEMENTS & CONSENT: I, the undersigned, consent to treatment from the staff of Memory & Psychological Services, Inc. and acknowledge that I have read, understand, and agree to the policies stated above.

PATIENT NAME: (please print) _____

PATIENT SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN/GUARANTOR: (please print) _____

PARENT/GUARDIAN/GUARANTOR SIGNATURE: _____ DATE: _____

Please sign here ONLY if you are choosing to OPT OUT of the research initiative (see above): I do not want information about me/the patient to be used in research, even with all identifying information removed.

Signature: _____ Date: _____