# PEDIATRIC NEUROPSYCHOLOGY SERVICES, PLLC

MICHELLE LURIE, Psy.D., ABPdN

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## PATIENT REGISTRATION

This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which was provided separately, explains HIPAA and its application to your personal health information in greater detail. When you sign this document, it will also represent an agreement between us and your understanding of the limitations on confidentiality.

**PATIENT:** _____ Today's Date: _____/_____/_____
First Name Middle Last Name
Social Security #: _____/_____/_____ Sex: M F Date of Birth: ___/ ___/____ Age: ____
Address:_____
Street City State Zip
Home Phone: _____ School Name: _____Grade:_____
School Address_____Phone: _____
Primary Care MD: _____Phone: _____
Major Health Problems: _____
Medications currently taken: _____
Have you seen a mental health professional before, if so please give name, date and reason: _____
_____
Referred by:_____ Address: _____
Phone Number:_____ May I have your permission to thank this person for the referral ? Y N

**PARENT'S NAME:** _____
First Name Middle Last Name
Social Security #: _____/_____/_____ Sex: M F Date of Birth: ___/ ___/____
Address (if different from above)_____
Street City State Zip
Home Phone: _____ Work Phone: _____ Cell Phone_____
Okay to call at work: Y N Email Address:_____
Employer: _____ Occupation: _____
Highest Level of Education:_____
Marital Status: (circle) Married Single Divorced Separated
Name of Stepparent (if applicable)_____

**PARENT'S NAME:** _____
First Name Middle Last Name
Social Security #: _____/_____/_____ Sex: M F Date of Birth: ___/ ___/____
Address (if different from above)_____
Street City State Zip
Home Phone: _____ Work Phone: _____ Cell Phone_____
Okay to call at work: Y N Email Address:_____
Employer: _____ Occupation: _____
Highest Level of Education:_____
Marital Status: (circle) Married Single Divorced Separated
Name of Stepparent (if applicable)_____

Custodial Parent/Guardian:_____

I have provided a copy of the divorce decree/custodial agreement: Y N NA

**SIBLINGS' NAMES AND AGES:** _____ _____
_____

**EMERGENCY CONTACT**

If some kind of emergency arises and I can not reach you directly, or I need to reach someone close to you, whom should I call?

Name:_____ Phone:_____

Address: _____

**INSURANCE AND BILLING INFORMATION**: Method of Payment: (circle) check cash

Primary Insurance Company: _____Group #: _____

Policy Holder's Name: _____ Date of Birth: ___/ ___/_____

Policy Holder's SSN#: _____ Employer: _____

Patient's relationship to insured: (circle) Self Spouse Child Other

**PATIENT RESPONSIBILITY**:

1. **A payment is required after each session, unless prior arrangement is made with Dr. Lurie.**
2. **Your receipt may be submitted with your insurance form to the carrier.**
3. **Fees will be charged for each scheduled appointment unless cancelled 72 business hours in advance by phone. Appointments cancelled with less than 72 business hours notice will be billed at the full fee (please initial)_____.**
4. **If you need to contact Dr. Lurie, you may call (972)248-3682 and leave a message. Dr. Lurie checks messages on a regular basis and your call will be returned as soon as possible. In a life threatening emergency, please call 911 or go to the nearest emergency room.**

**You have been provided the "Notice" and understand limits to the disclosure of your protected health information.**

- ☐ **I give my consent for releasing minimum necessary information to insurance carrier.**
- ☐ **I do not give my consent for releasing information to insurance carrier.**

**Please sign below indicating that you understand and accept financial responsibility for treatment and understand the uses and disclosure of protected health information.**

Signature Date