CONNECTICUT NEURODEVELOPMENTAL SERVICES

134 GRANDVIEW AVE.
SUITE #208
WATERBURY, CT 06708
(203) 755-3279 FAX (203) 755-3057

PATIENT REGISTRATION

Patient: _____
(Last Name, First name, Middle Initial)

Date of Birth: _____ Male: ☐ Female: ☐ Pediatrician: _____

Social Security Number _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

School: _____ Grade: _____

Parent/Guardian Information:

Mother: _____ Single Married Separated Divorced
(Last Name, First name, Middle Initial)

Address/P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Business Phone: _____ City: _____ State: _____ ZIP: _____

Father: _____ Single Married Separated Divorced
(Last Name, First name, Middle Initial)

Address/P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Business Phone: _____ City: _____ State: _____ ZIP: _____

**** If mother & father are not living together or the child does not live with parents, what is the child's custody status?**** _____

In case of an emergency who may we contact?

Name/PhoneNumber:_____

Name/Phone Number:_____

Name/Phone Number:_____

Insurance Information: *Please present insurance card at every office visit*

Primary Policy Holders Name:_____ Date of Birth:_____

Primary Insurance Company:_____ Copay:_____

Primary Insurance ID: _____ Group:_____

Primary Insured Employer:_____ S.S.#_____

Secondary Policy Holders Name:_____ Date of Birth:_____

Secondary Insurance Company:_____ Copay:_____

Secondary Insurance ID: _____ Group:_____

Secondary Insured Employer:_____ S.S.#_____

Financial Arrangement

If my insurance plan requires an authorization for this visit and any follow-up visits, it is my responsibility to ensure that the referral is current and on file with CNS.
I am aware that my insurance CoPay/Deductible is to be paid at the date of service.
I am aware that if CNS does not participate with my plan or if I have no insurance coverage, payment will be collected at time of service.

All payment arrangements must be made in advance. In the case of default of payment, I agree to pay collection cost and all attorney fees. I authorize CNS to release any information to third party payers for payment of charges. I authorize my insurance company to pay directly to CNS. I also agree to be responsible for payments of all services rendered on behalf of myself, or my dependants.

Signature:_____ Date:_____

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NO SHOW POLICY

If you are not planning to show up for your scheduled appointment, you must contact our office. If possible, at least 24 hours notice should be given. This way, we may be able to offer your time slot to another patient.

If the patient does NOT-SHOW for 1 visit, they are discharged

We regret that we have been forced to develop this policy but it is important to us that we continually strive to provide the most effective and efficient care possible.

Name of Patient:_____ DOB:_____

_____ _____
Signature (Responsible party) Date

_____
Relationship to patient (if applicable)

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Financial Policy

We, here at Connecticut Neurodevelopmental Services are dedicated to providing you with the best possible care and service. It is essential that you have a clear understanding of your financial responsibilities. Unless you or your health insurance carriers have made other arrangement in advance, full payment is due at the time of service for co-pay/co-insurance or deductible. For your convenience, we accept Visa, MasterCard, Discover and cash as form of payment but we no longer accept personal checks.

Referrals:

It is the patient's/parent's/legal guardian's responsibility to make sure that all referrals from the primary care provider/pediatrician are in place prior to a scheduled appointment. If the insurance requires an insurance referral and patient continues care with our office, it is the patient's/parent's responsibility to keep track of the referral dates and obtain a new one prior to the follow up appointment. Failure to have proper referrals will result in patient/parent/guardian being responsible for full payment of services on the day of the appointment; otherwise the appointment will be cancelled.

Insurance Coverage:

We have arrangements with most insurance plans to accept their fee schedules. We will submit claims on your behalf to the insurance carriers with whom we participate. Please check with your insurance carrier to see if we are in network with them. It is your responsibility to know your individual benefits and the limits on your health insurance plan. In the event your health plan determines that a service is not covered, you will be responsible for the entire charge and payment is due upon receipt of our billing statement. If we do not participate with your insurance plan, or not eligible with

the insurance and you still want to be seen, you are responsible for payment in full on the day the service is rendered. You are also responsible for notifying our office whenever your insurance changes. If we run out of timely filing due to incorrect insurance, you will be responsible to pay in full for our services.

Co-pay is collected the same day you receive our services. If you have a plan with a deductible, we collect our contracted amount before the patient is seen and before claims are submitted to your insurance. Benefits are always checked online; therefore we are able to access the patient's current insurance coverage, unless the patient has met his/her deductible through some unforeseen circumstances between the visit and our claim submission. In that case the collected amount, which was also paid by the insurance, will be refunded.

Minor Patients:

Parent or a legal guardian must accompany any patient under the age of 18 years and any payment due is the responsibility of the parent or guardian on the date of service.

Appointment:

Appointments are scheduled to accommodate as many patients as possible on a given day. We require a minimum of 24 hours for cancellation of an appointment unless there is an emergency situation. If you are late for your appointment, please call our office to see if we are still able to accommodate you at your arrival time. Please be aware that you may be asked to reschedule that appointment in an effort to prevent delaying other patients who have arrived on time.

Missed Appointments:

We reserve the right to charge you a missed appointment fee of $50.00 for a consultation, an EEG or ADHD Testing and $25.00 for a missed follow up if the appointment is not cancelled 24 hours in advance. This charge is not billable to your insurance carrier and is your responsibility. When you do not keep your appointment, you hold a valuable spot for another patient who requires medical care. Your

consideration by arriving on time for your scheduled appointment is essential to all patient care.

We do not reschedule missed consultations and we do not reschedule patients after 2 missed follow ups.

Motor Vehicle Accidents and Liability Services:

As a courtesy, we will bill your (MVA) or liability insurance carrier. Should your policy exhaust (meaning your coverage for med-pay has been fully used) you are responsible for any balance due, which is payable upon receipt of our billing statement. Accidents involving litigation do not absolve you from your financial responsibility to Connecticut Neurodevelopmental Services – due upon receipt of our billing statement. We do not accept "Letter of Protection". You are to collect any settlement monies from your attorney.

Delinquent Accounts:

Payment is due at the time of service, unless arrangements have been made due to extenuating circumstances prior to your appointment. Accounts that are past due will not accumulate finance charges, but if the account becomes 90-days past due may be sent to a collection agency, small claims court or our attorney. Parents/guardians who sent to collection or court will be responsible for collection agency fees, court costs and legal fees in addition to the original outstanding balance. Once a patient is sent to collection, all services provided by Connecticut Neurodevelopmental Services will be terminated.

Insurance Authorization and Financial Policy Agreement:

I hereby authorize Connecticut Neurodevelopmental Services to furnish information to my insurance carrier concerning my illness and treatment necessary to process my claims. I acknowledge that I have received a copy of Connecticut Neurodevelopmental Services' Financial and Privacy Policy.

I have read and understand the financial policy of this practice, and I agree to be bound by it's terms and conditions therein. I also understand and agree that such terms may be amended from time to time by the Practice.

Signature of patient/parent/legal guardian	Date
Please print the name of the person signing	
Please print the name of the patient	Completed by (staff)

Acknowledgment of Receipt of Notice of Privacy Practices

(Electronic Version)

PRIVACY POLICIES AND PROCEDURES

This Notice of Privacy Practices is made available to you via our website and/or at your request. Please fill out the document and return to:

Connecticut Neurodevelopmental Services
134 Grandview Avenue, Suite# 208
Waterbury, CT 06708
Fax# (203) 755-3057

I, _____ have been offered a copy of Connecticut Neurodevelopmental Services' "Notice of Privacy Practices". This notice describes in detail how my Protected Health Information (PHI) may be used or disclosed by Connecticut Neurodevelopmental Services according to HIPAA regulations and further describes my rights under HIPAA.

Please check one box below:

☐ I have been offered a copy of the Notice of Privacy Practices and acknowledge I have received a copy.

☐ I have been offered a copy of the Notice of Privacy Practices and am DECLINING to accept a copy.

Your signature below documents that you have been offered the Notice of Privacy Practices.

_____ _____
Signature of Patient Date

_____ _____
Printed name of authorized representative Date

_____ _____
Signature of authorized representative Relationship to Patient

☐ Patient or authorized representative refused to sign this acknowledgement. _____
Printed name of CNS employee

Implemented: April 14, 2003

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Addendum to Financial Policy

We participate with most insurance carriers. However, you must clearly understand and agree that:

1. Your insurance policy is a contract between you, your employer and the insurance carrier. Our relationship is you, NOT the insurance company.

2. All charges incurred are charged directly to YOU and you are personally responsible for payment.

3. Deductibles and co-payments are due at the time of treatment. We estimate your co-payment/deductible according to your policy and DO NOT in any way guarantee that your carrier will pay this amount.

4. If your insurance does not pay with in a reasonable amount of time, it is required that you pay the balance due.

5. Your insurance card MUST be presented at the initial visit. If there is no insurance card then payment (CASH, CHECK, OR CREDIT CARD) is expected at the time of service.

We understand that temporary financial problem may occur. We encourage you to communicate any such problems with our office so that we can assist you in managing your account.

Parent/Guardian Signature:_____ Date:_____