New Patient Referral - Neuropsychology/Psychology

Date: __/__/__
Initial: _____

Patient Name: _____

New Pt _____
Current Pt _____

Service Requested **Pediatric:** ___ **Adult:** ___

Neuropsychological Testing _____
SNT _____
Psychological Assessment _____
Psychotherapy _____
Other _____

Reasons/Symptoms _____

Clinician Referred To: _____
***Contact Person:** _____
Phone #: (_____) _____
Primary M.D. _____
Phone # (_____) _____

Referred By: _____
Address: _____
Phone #: (_____) _____
Records Requested? Yes / No
Records Here? Yes / No

Patient Information

Name: _____ **Age:** _____ Sex: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: Home: (_____) _____ Work: (_____) _____
DOB: _____/_____/_____ SS#: _____/_____/_____
Father: _____ Work: _____ Mother: _____ Work: _____
Cell: _____ Cell: _____

Insurance Information

Insurance 1 _____ Insurance 2 _____
Policy Holder: _____ Policy Holder: _____
Relation to Patient: _____ Relation to Patient: _____
ID #: _____ ID #: _____
Group #: _____ Group #: _____
Phone # for benefits: _____ Phone # for benefits: _____

Not covered at MEG- Reason: _____
Benefits: In / Out Network
Referral needed: Yes / No From: _____
Deductible: _____ OOP Max $_____
Copay: $_____ Coinsurance $_____
Provider to get authorization: Yes / No
Patient to get authorization: Yes / No

Patient informed/benefits: _____
Payment arrangements: _____
OON/Disclaimer Sent: _____
Collection Policy: _____
Appt Letter sent: _____
Packet sent: _____
Directions: _____
ROI: _____
Cancellation Policy: _____

Appt Date/Time: _____ **Copy to provider:** _____