FOCUS CENTERS, PLLC

Please fill in **ALL** *blanks*

417 Biltmore Ace, Suite 5-D
Asheville, NC 28801

*Date:*_____

New Patient Information

Please **PRINT**
Patient *Name:* _____ ☐ *Male* ☐ *Female*
Last *First* *Middle Initial*

Mailing Address: _____

_____, _____ *Zip*_____ *Parent/Adult Email Address:* _____

*Home Phone :*_____ *Birthday:*_____ *Social Security #*_____;

☐ *Married* ☐ *Single* ☐ *Widowed* ☐ *Divorced* ☐ *Other:* *Age*_____

Employer:_____ *Work Phone # :* _____

*Address:*_____
City *state* *zip*

Do you have Insurance Coverage? Yes / No *Secondary Insurance? Yes / No*
Medicare Coverage? Yes / No *Medicaid Coverage? Yes / No*

(front and back copy of insurance card is required)

INSURANCE:
*Company:*_____ *ID #*_____*Group #*_____

*Address:*_____

_____,_____,_____
city *state* *zip*

*Phone #*_____ *Relationship to Insured*: ☐ *Self* ☐ *Spouse* ☐ *Child* ☐ *Other*

*Name of Insured:*_____*Birthday*_____*SS # of insured* _____

*Address if different:*_____
City *state* *zip*

SECONDARY INSURANCE:
*Company:*_____ *ID #*_____*Group #*_____

*Address:*_____

_____,_____,_____
city *state* *zip*

*Phone #*_____ *Relationship to Insured:* ☐ *Self* ☐ *Spouse* ☐ *Child* ☐ *Other*

*Name of Insured:*_____*Birthday*_____*SS # of insured* _____

*Address if different:*_____
City *state* *zip*

*Reason for visit:*_____

*Primary Care Physician:*_____*Referred to Office by:*_____

*Spouse or Parent*_____ *relationship*_____*phone #*_____
Circle *Last name* *first* *Initial*

MEDICARE PATIENTS: Your provider is a Medicare provider and will file your claim. As a Medicare patient, you will be responsible, by law, for your yearly deductible and the 20% (co-insurance) due after the Medicare payment has been paid to us. If you have a secondary insurance, we will file only if your company is a Medigap crossover. In the event your insurance company is not a Medigap member, we will be unable to file to the secondary insurance company. If, after 45 days, the Medigap crossover claim is not paid, or if you do not have a secondary insurance coverage policy, you will be responsible for the remaining balance. Should you have any questions as to whether your secondary insurance company is a Medigap crossover company, please feel free to inquire with our office management.

- **SIGNATURE:**_____**Date**_____

INSURANCE PATIENTS: Your provider, will file your claim to your primary carrier, with the information you provide. You will be responsible for your yearly deductible, copay,co-insurance and other fees not covered by your insurance. If, after 45 days, your claim is not paid, or if you do not have an insurance coverage policy, you will be responsible for the remaining balance.

- **SIGNATURE:**_____**Date**_____

REASSIGNMENT OF BENEFITS: I authorize Focus Centers, PLLC, or my provider,or any holder of medical information to release any information, original or copies, needed to pay/process a claim I may file. I Hereby authorize payment to Focus Centers benefits specified and otherwise payable to me for any services rendered subsequent to this date and for such other charges as may be made by his office. I agree to pay for charges not covered/denied by my insurance.

- **SIGNATURE**_____ **Date**_____

AUTHORIZATION / PRE-CERTIFICATION: does you insurance require ? ☐ *Yes* ☐ *No*
If yes, authorization or precert # _____

MediClaims Link is the patient account and billing firm that will process your claim. We respect the privacy of each patient and will hold patient information confidential. Please call if you have questions about your account 828.299.0054

For office notes:			

FOCUS: Center for Neurofeedback, PLLC
Phillip Ellis, Ph.D.
29 Ravenscroft Dr
Asheville, NC 28801

Please fill in **ALL** *blanks*

*Date:*_____

New Patient Information
Parent or Guardian Supplement

Please **PRINT**
Parent or Guardian Name: _____ ☐ *Male* ☐ *Female*
Last *First* *Middle Initial*

Mailing Address: _____

_____, _____ *Zip*_____

*Home Phone :*_____ *Birthday:*_____ *Social Security #*_____;

☐ *Married* ☐ *Single* ☐ *Widowed* ☐ *Divorced* ☐ *Other:* *Age*_____

Employer:_____ *Work Phone # :* _____

*Address:*_____
City *state* *zip*