New Peaks
NEUROPSYCHOLOGY

PATIENT INFORMATION

Please fill out this form completely & sign where indicated.

777 29th St., Suite 200
Boulder, CO 80303

Today's Date _____

Name of Patient _____
Last First Initial Nickname

Address _____
Street City State Zip Code

Date of Birth _____ Email Address _____

Home Phone _____ Cell Phone _____

Sex Assigned at Birth: _____ Gender: _____ Check: Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed ☐

Your Primary Physician _____ Physician Phone _____

Who is responsible for payment? _____

SPOUSE, PARTNER, PARENT(s)/ GUARDIAN(s)

Name _____
Last First Initial Nickname

Address _____
Street City State Zip Code

Home Phone _____ Cell Phone _____

Email Address _____

WHO REFERRED THE PATIENT TO US – PLEASE NAME BELOW

_____ / _____
Referring Doctor's Name/ Phone Referring Person's Name/ Relationship/ Phone

INSURANCE INFORMATION

Insurance information is collected by our billing office. If you have coverage for **Out of Network Neuropsychological Services**, our billing office can assist you in obtaining reimbursements.
To avoid error or delay in the processing of any insurance claims, it is essential that this section be COMPLETELY FILLED OUT.

Do you have health insurance to cover these services? ☐ YES ☐ NO

Heath Insurance Company _____

Claims Address _____

City _____ State _____ Zip _____

Insurance Phone _____ ID # _____ Group # _____

Policy Holder Name _____ Policy Holder Date of Birth _____

Employer _____

PLEASE SIGN BY BOTH X'S

I authorize payment of medical benefits to undersigned physician or supplier for these services and all future claims.
X _____

I authorize the release of any medical information necessary to process this claim and all future claims.
X _____