NEAL McGRATH, Ph.D. & ASSOCIATES
NEUROPSYCHOLOGY NEW ENGLAND
SPORTS CONCUSSION NEW ENGLAND

Neal McGrath, Ph.D.
Clinical Director

Alexandra Jackson, Psy.D.

NEW CLIENT INFORMATION Today's date ___________

Client Name __________________________ Date of birth ________ Age _____

Address _____________________________ Phone - Home ( ) ___________

_____________________________ - Cell ( ) ___________

email _______________@_____________ - Work ( ) ___________

School ______________________________ Grade/year ____________________

(If under 18) Parent/Guardian _________________Phone _____________ email_____________

Parent/Guardian _________________Phone_____________ email _____________

Referred by ____

Reasons for evaluation:

____

Date of this concussion __________________ Number of prior concussions ____________

Current concussion symptoms: ____

____

____

____

Current prescription medications:

Name	Dosage	Reasons	Doctor

Medical Insurance ____________________________ Policy # _____________________

Subscriber _______________________________ Subscriber's date of birth __________

Primary Care Physician ____________________________ Phone __________________

Psychiatrist ______________________________________Phone __________________

Neurologist ______________________________________Phone __________________

Psychologist/Therapist ____________________________Phone __________________

PLEASE COMPLETE SIDE 2 >>>

1368 Beacon Street – Suite 116, Brookline, Massachusetts 02446
617-959-1010 Office / 617-734-0734 Fax
www.NeuropsychNewEngland.com
www.sportsconcussion.net

If you are paying by insurance, co-payments are due at the time of visit. Please have payment ready for Dr. McGrath or Dr. Jackson

AMOUNT OF PAYMENT $ _______ (Circle one) Cash, Check, MC, Visa, Discover, or Amex

If paying by credit card for visit; co-payments; co-insurance; deductible etc:

Credit Card # _________________________________ Expiration Date: ________________

Name on Card: _______________________________ CSV Code:____________

Please initial here that you agree for us to charge your card _____

Please note that if your health insurance does not cover **part or all** of this appointment (for any reason), you have not obtained prior authorization/referrals to be seen in this office, or if you have not verified deductibles, co-insurance or co-payments due with your insurance, there will be a client responsibility for the uncovered portion and could include $3200 (for full neuropsychological evaluation), $395 (for initial brief clinical interview) or $195 (brief follow-up clinical interview) unless other arrangements have been made.

____

Signature Date

I have read and understand the above paragraph.

Please note that payment for each office visit covers interviews, records review, testing, and a written report only. Any additional services requested that are not covered by insurance, including phone calls by the doctor to other professionals, writing of letters, etc. will be billed to you at the rate of $175 per hour.

____

Signature Date

I have signed and understand the above paragraph

Financial Responsibility: I understand that all professional services rendered are charged to the patient and are due at the time of services unless other arrangements have been made in advance with Neuropsychology New England (NNE)/Sports Concussion New England (SCNE). It is my responsibility to inform NNE/SCNE of any insurance changes that may affect my benefits. I understand that I am responsible for any amount not covered by insurance.

Assignment of Benefits I hereby assign all insurance benefits directly to Neuropsychology New England (NNE)/Sports Concussion New England (SCNE). I hereby authorize my insurance carrier(s), to issue payment directly to NNE/SCNE. I understand and agree that this Assignment of Benefits will remain in effect for the duration of my evaluation/treatment with NNE/SCNE, or until such time that I revoke my authorization in writing.

Authorization to Release Information I authorize the release of any medical, psychological, or other information to my Insurance Carrier(s) or any other authorized entity necessary to determine medical insurance benefits, To receive benefits payable for services rendered, or for authorization to approve services. I understand that a copy of this assignment may be sent to my Insurance carrier(s) if request and the original will remain on file at NNE/SCNE

____

Signature Date

I have signed and understand the above paragraph