River Valley Neuropsychology, LLC

322 Main Street, Suite 2E-1N
Willimantic, CT 06226

Tel: (860) 230-8851
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Registration Form

Patient Information

Name: _____ **DOB**: _____/_____/_____

Address: _____ **Phone**: _____

_____

Marital Status: Single Married Divorced Separated Widowed

Occupation: _____

Employer: _____ **Employer Phone**: _____

Primary Care Physician: _____

Insurance Company: _____ **Number**: _____

Secondary Insurance:_____ **Number**: _____

In Case of Emergency:

Name of local friend or relative: _____ **Phone**: _____

Relationship to patient: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to River Valley Neuropsychology, LLC. I understand that I am financially responsible for any balance. I also authorize River Valley Neuropsychology, LLC or insurance company to release any information required to process my claims.

In case of emergency, I authorize River Valley Neuropsychology, LLC to contact the above person on my behalf.

_____ _____
Signature of Patient/Legal Representative* Date

**If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.*