
# Nashville NeuroCare Therapy

2001 Mallory Lane, Suite 304
Franklin, TN 37067
Phone 615-465-4875
www.nashvilleneurocare.com

**Patient Information**:

Last Name: _____ First: _____ MI: _____

Prefers to be called (if different from legal name): _____

Address:
_____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____
* Please indicate if you do not want us to leave voice mail on the phone numbers listed.

Date of Birth: ____________ Age: _____ Sex: MALE / FEMALE

Social Security #: _____-_____-_____

**Personal Information**:

Spouse's Name: _____ Phone:
_____

Patient Employer/Occupation: _____Phone: _____

Emergency Contact: _____ Phone: _____

## **Electronic Mail (EMAIL) Policy**:

By agreeing to communicate via email, you are assuming a certain degree of risk of breach of privacy beyond that inherent in other modes of traditional communication (such as telephone, written, or face-to-face). We cannot ensure the confidentiality of our electronic communications against purposeful or accidental network interception. Due to this inherent vulnerability, we will save email correspondence with you and these communications should be considered part of the medical record; therefore, you should consider that our electronic communications may not be confidential and will be included in your medical chart. Never send emails of an urgent or emergent nature and please contact the office if you have not received a reply within 24 hours.

*I have read and agree to the terms of the email policy X_____

Email address: _____

**Payment Policy**:
Payment may be made by cash, check or credit card.

**Appointment Charges / Cancellation Policy**:

We do not overbook appointments and appointments made are reserved for the patient. We require a **24-hour cancellation notice**. Patients will be charged the full session rate if they do not cancel an appointment within the 24-hour time frame. Patients will also be charged the full session rate if they fail to keep their appointment on the day it is scheduled. Insurance does not cover missed or cancelled appointments. If you need to change or reschedule an appointment, please call our office as soon as you can so we can accommodate other patients who wish to be seen.

* For your convenience, we are able to keep a credit card on file to charge at your appointments. If you would like to use this service, please fill in the information below.

**Credit/Debit Card Payment for appointments**:

_____ Visa _____ Master Card _____ Discover _____ AMEX

Security Code _____

Name as it appears on Card: _____ Billing Zip Code _____

Credit/Debit Card #: _____ Exp. Date _____

I/we authorize **Nashville NeuroCare Therapy** to bill the above credit/debit card for professional services at the time of service. I will notify **Nashville NeuroCare Therapy** in writing if I no longer want my credit/debit card billed.

Signature: _____ Date: _____

**Credit/Debit Card Payment for missed or cancelled appointments**:

I authorize **Nashville NeuroCare Therapy** to charge the above credit/debit card when the patient does not give advanced notice for a late-cancellation or no-show, as per the policies. I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees and will be billed accordingly.

Signature: _____ Date: _____

**Insurance Policy:**

Nashville NeuroCare Therapy/neuroCare Centers of America is contracted with Medicare, BCBS TN and United Behavioral Health/Optum. We will file your insurance for you and you will be responsible for any deductible or copay as determined by your insurance company.

For all other insurance companies that **Nashville NeuroCare Therapy** is out of network with we are happy to file your insurance for you, however, payment will be due in full at the time of service.

**Payment Policy:**

Payment for TMS treatment is due in full at the beginning of treatment.

**Emergencies**:
To reach your doctor after office hours call the main office at 615-465-4875 and leave a voicemail, your doctor will be contacted and return your call within 24 hours. If you are experiencing an emergency and cannot wait, please call 911.

**Guarantor Information (complete only if the patient is NOT paying for the bill)**:

Name of party responsible for bill: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Phone: _____

Date of Birth: _______________ SS#: _____

**Guarantor-Financial Responsibility Agreement**:

I, the undersigned, regardless of any insurance coverage, am financially responsible for all charges generated for this patient. Office policy requires payment at the time of service. I understand that unpaid balances over 30 days may be subject to a late fee. I understand that unpaid balances over 90 days are past due and may be referred to a collection agency.

Signature: _____ Date: _____

**Termination of Treatment**:

Patients are not obligated to continue treatment. If you decide to terminate at any time, you are encouraged to discuss your decision to terminate care with your doctor.

**Consent to Treatment and Patient/Guarantor Responsibility**:

I have read the policies listed above and I understand and agree to them. I agree to be treated by **Nashville NeuroCare Therapy**, and when necessary, any doctors covering in his absence. I agree that I am responsible for all charges for services rendered and I agree to adhere to the payment policies.

If I choose to have my insurance filed for me I hereby authorize payment by my insurance company directly to **Nashville NeuroCare Therapy.**

I hereby authorize **Nashville NeuroCare Therapy** to release any information my insurance company may require concerning patient care in regard to billing or prescription needs.

Patient's Signature (Parent or Guardian, if minor): _____

Date: _____