Patient Registration

NEURODEVELOPMENTAL INSTITUTE OF NEW HAMPSHIRE

- ❑ New Client
- ❑ Returning Client
- ❑ Added/Updated in CR
- ❑ Eligibility
- ❑ VOB
- ❑ Payment Contract
- ❑ Consents Created
- ❑ Intake Scheduled _____
- ❑ Consents Sent _____
- ❑ Chart # _____

***All fields must be filled out or marked NA as appropriate. ***

Date: _____

What services are you requesting an appointment for? (check all that apply)

- ❑ testing
- ❑ therapy
- ❑ EMDR
- ❑ NFB
- ❑ LHI
- ❑ medication management
- ❑ update information
- ❑ other_____

If client is a minor, both parents must provide consent for services or proof of sole decision-making rights. Parental consent from both parents or proof of sole decision-making rights ***must be received PRIOR to intake or the appointment will be rescheduled.*** Client is:

- ❑ an adult.
- ❑ child lives with both parents; both parents can sign the Permission for Services.
- ❑ parents share joint parenting rights and responsibilities; *both parents can sign the Permission for Services or Consent for Treatment of Minors When Parents Share Custody can be used.*
- ❑ one parent/guardian has sole parenting rights and responsibilities; *parent must provide proof PRIOR to intake or the appointment will be rescheduled.*
- ❑ other parent is deceased.
- ❑ DCYF has guardianship.
- ❑ other: _____

Patient Information

First name: _____ MI: _____ Last name: _____

Date of birth: _____ Gender: _____ Marital status: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

Does the patient have any of the following? (check all that apply, and instruct to bring copies for file to intake)

- ❑ insurance cards (we will take copies of all insurance cards)
- ❑ previous testing
- ❑ past/current medication list
- ❑ IEP
- ❑ 504

Guarantor (Person Financially Responsible for Payment)/Parent or Guardian 1

First name: _____ MI: _____ Last name: _____

Date of birth: _____ Gender: _____ Marital status: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

Parent or Guardian 2/Emergency Contact

First name: _____ MI: _____ Last name: _____

Date of birth: _____ Gender: _____ Marital status: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

**** All insurance fields must be filled in BEFORE Verification of Benefits can be completed. ****

Primary Insurance Information

Insurance co.: _____ Plan name: _____

Member ID: _____ Group #: _____

Insurance phone: _____

Subscriber first: _____ MI: _____ Last: _____

DOB: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

Secondary Insurance Information

Insurance co.: _____ Plan name: _____

Member ID: _____ Group #: _____

Insurance phone: _____

Subscriber first: _____ MI: _____ Last: _____

DOB: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

Client has Well Sense insurance? yes no ****If yes, an initial auth. must be added to the client profile in CR after VOB.***

Next Steps

Review the next steps with client/guardian:

- ❑ verification of insurance benefits will be completed
- ❑ Welcome Packet with required consents and acknowledgements will be sent:
  - ❑ Email to: _____
  - ❑ Mail to: _____
- ❑ intake appointment will be schedule AFTER all signed consents are received.