PLEASE NOTE: INSURANCE POLICIES DO NOT USUALLY COVER ANY SERVICES THAT ARE RELATED TO LEARNING DEVELOPMENTAL PROBLEMS OR EDUCATIONAL ISSUES, TESTING MAY INCLUDE THESE PROCEDURES-YOU ARE RESPONSIBLE FOR THESE CHARGES.

NEUROPSYCHOLOGY ASSOCIATES OF FAIRFAX, LLC

PATIENT INTAKE INFORMATION:

NAME OF PATIENT: _____

COMPLETE ADDRESS:

_____

_____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

HOME TELEPHONE: (____) _____ WORK: (____) _____

CELL: (____) _____ EMAIL:_____

Neuropsychology Associates of Fairfax is mandated by The Affordable Care Act to collect the following information which will be used by HHS to collect demographic data on Healthcare delivery

ETHNIC GROUP: **HISPANIC OR LATINO** **NON HISPANIC OR LATINO** **DECLINE** (CIRCLE ONE)

RACE: **AMERICAN INDIAN OR AK NATIVE** **ASIAN** **BLACK OR AFRICAN AMERICAN**

NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER **WHITE** **DECLINE** (CIRCLE ONE)

WHO REFERRED YOU: _____

IS THIS THE RESULT OF AN AUTO OR WORK RELATED ACCIDENT: **Y / N** (CIRCLE ONE)

PRIMARY INSURANCE NAME: _____

MEMBER ID NUMBER: _____

GROUP NUMBER: _____

NAME AND BIRTH DATE OF SUBSCRIBER: _____

RELATION TO THE INSURED: **SELF** **SPOUSE** **CHILD** OTHER (CIRCLE ONE)

FOR MEDICARE PATIENTS ONLY: MEDIGAP INSURANCES

MEDIGAP INSURANCE: _____

MEMBER ID NUMBER: _____

GROUP NUMBER: _____

NAME AND BIRTH DATE OF SUBSCRIBER: _____

RELATION TO THE INSURED: **SELF** **SPOUSE** **CHILD** OTHER (CIRCLE ONE)