Neurobehavioral Consultants

Patient Information

Patient Name: _____ Date of birth: _____

Street address: _____

Town: _____ State: _____ Zip code: _____

Telephone: _____ Other phone, work/cell: _____

Primary Insurance: _____ Policyholder's Name: _____

Policy Number: _____ Policyholder's date of birth: _____

Relationship to patient: __self __spouse __parent __step-parent

Employer: _____

Secondary Insurance: _____ Policyholder's Name:_____

Policy Number: _____ Policyholder's date of birth:_____

Relationship to patient: ___self __spouse ___parent __step-parent

Employer: _____

Insurance Claim Processing Disclaimer

I authorize the release of medical or other information necessary to process insurance claims. Such information is to be released only for the purpose of filing health insurance claims with insurance companies and related agencies. I authorize payment of medical benefits directly to Neurobehavioral Consultants, LLC., or its designee for any services rendered.

Signature: _____ Date: _____

Print Name:_____
If signing for minor