Ascent Neurobehavioral Institute
540 West Plumb Lane, Suite 1A
Reno, Nevada 89509
775-322-4666
Fax 775-322-4747

**PATIENT INFORMATION**

Thank you for choosing Ascent Neurobehavioral Institute. Please fill out this form completely in order to ensure the fastest and best healthcare service. Please use only blue or black ink.

**Name:**______________________________________________
First Middle Last

**SS#:**________________ **DOB:**________________ **Gender:** Male Female

**Address:**______________________________________________
Street Apt.# City State Zip Code

**Home Phone#:**______________ **Work Phone#:**______________ **Cell Phone#:**______________

**Marital Status:** S M W D **Employment:** Employed/ Disabled/ Unemployed/ Student/ Retired

**Email Address:**______________________ **Spouse's Name:**______________________

**Primary Care Physician:**______________________ **Phone #:**______________

**Other Therapist:**______________________ **Phone #:**______________

**Pharmacy Name:**______________ **Location:**______________ **Phone#:**______________

**EMERGENCY CONTACT INFORMATION:**

**Emergency Contact Person:**______________________ **Relationship to Patient:**______________

**Home Phone#:**______________ **Work Phone#:**______________ **Cell Phone#:**______________

**IF PATIENT IS A MINOR:**

**Mother's Name:**______________________________________________
First Middle Last

**Address:**______________________________________________
Street Apt# City State Zip Code

**Home Phone#:**______________ **Work Phone#:**______________ **Cell Phone#:**______________

**Father's Name:**______________________________________________
First Middle Last

**Address:**______________________________________________
Street Apt# City State Zip Code

**Home Phone#:**______________ **Work Phone#:**______________ **Cell Phone#:**______________

**RESPONSIBLE PARTY:** (Complete this section only if someone other than the patient is financially responsible)

**Name:**______________________________________________
First Middle Last

**Relationship to Patient:**______________ **SS#:**______________ **DOB:**______________

**Address:**______________________________________________
Street Apt.# City State Zip Code

**Home Phone#:**______________ **Work Phone#:**______________ **Cell Phone#:**______________

**INSURANCE INFORMATION:**

**Primary Insurance Plan:**____________________________

**Insurance ID#:**________________ **Group#:**________________

**Subscriber Name:**____________________________
First Middle Last

**Subscriber SS#:**________________ **Subscriber DOB:**________________

**Subscriber Employer:**________________ **Employer's Phone#:**________________

**Secondary Insurance Plan:**____________________________

**Insurance ID#:**________________ **Group#:**________________

**Subscriber Name:**____________________________
First Middle Last

**Subscriber SS#:**________________ **Subscriber DOB:**________________

**Subscriber Employer:**________________ **Employer's Phone#:**________________

I certify that this information is true and correct to the best of my knowledge. I will notify the front office staff of any changes in any of the information listed, including insurance changes. I authorize Ascent Neurobehavioral Institute to release any medical information necessary to process my claims and payment of medical benefits to my insurance carrier(s).

________________________ ____________________
**Signature of Patient/Guardian/Responsible Party** **Date**

## ELECTRONIC PRESCRIPTION AUTHORIZATION

**Our office sends prescriptions electronically. Please complete the following information to ensure that your prescriptions are successfully sent to your pharmacy.**

Patient's Name:____________________________
(First) (Middle) (Last)

Address:____________________________
(Street) (Apt.#) (City) (State) (Zip)

Home Ph#:____________ Work Ph#:____________ Cell Ph#:____________

**LOCAL:**

Pharmacy Name:________________ Location:________________

Pharmacy Phone:________________ Pharmacy Fax:________________

**MAIL ORDER:**

Pharmacy Name:________________ Location:________________

Pharmacy Phone:________________ Pharmacy Fax:________________

***Please give a copy of your prescription drug card to the receptionist***

By signing below, I authorize Ascent Neurobehavioral Institute to submit my prescriptions electronically to my pharmacy. I understand that I will need to allow at least 48 hours for any refill request(s).

________________________ ____________________
**Signature of Patient/Guardian** **Date**

**Patient Record of Disclosures**

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to home or office, leaving messages on answering machines, and leaving correspondence with spouse or family member.

**I wish to be contacted in the following manner (circle all that apply):**

Home telephone number:______________________________________

- Leave a message with detailed information
- Leave a message with call back number only

Cell phone number:__________________________________________

- Leave a message with detailed information
- Leave a message with call back number only

Work telephone number:______________________________________

- Leave a message with detailed information
- Leave a message with call back number only

Written communication:

- Mail to my home address
- Mail to my work address
- Fax to this number:______________________________________

The following person(s) are able to speak with the doctor or office staff regarding my treatment or billing questions:

| Name (First and Last) | Relationship to Patient | Phone Number(s) |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |

This consent will remain in effect unless otherwise revoked in writing.

______________________________________ ____________________

Patient/Guardian Signature Date