NeuroGrow
BRAIN FITNESS CENTER
'BOOST YOUR BRAIN'

NEW PATIENT REGISTRATION AND AUTHORIZATION SHEET

Thank you for choosing NeuroGrow for your medical needs.

Please fax to (703)-462-9269 prior to your visit:

- **Brain MRI reports and images taken within last 6 months**
- **Bloodwork Results**
- **Any additional records you would like Dr. Fotuhi to review**

HOW DID YOU HEAR ABOUT US? _____

NAME: _____
First Middle Last

GENDER: _____ **DATE OF BIRTH:** _____

ADDRESS: _____

_____

EMAIL ADDRESS*: _____
* Enables access to online portal and other communication methods

HOME PHONE #:_____ **CELL PHONE #:**_____

MARITAL STATUS*: _____ **WORK PHONE#:**_____

LANGUAGE*: _____ **RACE*:** _____**ETHINICITY*:** _____
* Required by government mandate (although you may write "refuse")

CONTACT PREFERENCE: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Portal

MAY WE LEAVE A MESSAGE: ☐ YES ☐ NO

APPOINTMENT NOTIFICATION PREFERENCE: ☐ Phone ☐ Email ☐ Text ☐ NONE

PRIMARY CARE DOCTOR: _____ **PHONE NUMBER:** _____

EMERGENCY CONTACT PERSON: _____

RELATIONSHIP: _____ **EMERGENCY CONTACT #:**_____

PHARMACY INFORMATION

PHARMACY NAME: _____

ADDRESS/CONTACT INFORMATION: _____

8280 Greensboro Drive, Suite 240 | McLean, VA 22102 | Phone: (703) 462-9296 | Fax: (703) 462-9269 | www.neurogrow.com

HIPAA Consent

Receipt of Notice of Privacy Practices- Written Acknowledgment Form

We have a commitment to our patients to maintain confidentiality in all aspects of their care, medical, as well as financial. Please list designated individuals that you give NeuroGrow Brain Fitness Center to discuss confidential information:

Name:	Relationship:	Medical and/or Financial:
_____	_____	_____
_____	_____	_____

By signing this form, you acknowledge that NeuroGrow Brain Fitness Center has offered or given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. You consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. NeuroGrow Brain Fitness Center may condition treatment upon the execution of this consent.

Additionally, by signing this form, you acknowledge that by presenting yourself as a patient for medical care by Dr. Fotuhi and the staff of NeuroGrow Brain Fitness Center. You hereby grant full authority to Dr. Fotuhi and the respective assistants to administer and perform any and all treatments, tests, diagnostic procedures to or upon you, which may be advised, or necessary.

Patient Signature **X**_____ *Date* _____

PATIENT FINANCIAL RESPONSIBILITY FORM/INFORMED CONSENT

We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- I authorize NeuroGrow Brain Fitness Center to treat me and for payments for treatment, which are due in full at the beginning of each visit. Our assessment protocols and treatment services are covered by most insurance companies, except Medicare. **Dr. Majid Fotuhi is <u>not</u> an enrolled provider with Medicare.** You need to contact your own insurance provider to find out the extent of your coverage. We provide you with the necessary documentation that you can submit to them for full or partial reimbursement. To receive a copy of your records, please ask the front desk. There is a minimum $10 fee per report.

- We understand that sometimes you may not be able to make your appointments. Please notify us at least one day ahead of your visit. There will be a $25 fee for cancellation notices in less than 24 hours.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form

Patient Signature **X**_____*Date* _____

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