NEUROPSYCHOLOGY ASSOCIATES, P.C.
phone: 602-230-8324 **fax: 602-274-7402** **email:kempiak@neuropsychology-az.com**

CHILD

Name _____ Date _____

Sex____ Age _____ Birth Date ____/____/____ School _____Grade _____

Pediatrician _____ **Referred by** _____

PARENTS/GUARDIANS

Is this child adopted? Yes ☐ No ☐

Are custodial parents (circle one) together/separated/divorced If divorced, who has legal custody? _____

Mother/Guardian Name _____ (circle one) adoptive/biological/step-mother

Home Address _____
Street City State Zip

Father/Guardian Name _____ (circle one) adoptive/biological/step-father

Home Address _____
Street City State Zip

Who is responsible for payment for services rendered? _____

Is there an **attorney** involved in this case? Yes No Name _____

If your attorney has not requested an independent examination, we will only be responding to the referral questions of your referring clinician. We might not address specific medico-legal questions your attorney may have. If you have any questions about this issue, you should contact your attorney.

Contact Information

Name _____

Phone Number Home: _____

Work: _____

Cell: _____

Email: _____

Please circle preferred method of contact

Do we have your permission to leave a voicemail message for you at your home? Yes No

Do we have your permission to leave a message with a family member? Yes No

Do we have your permission to call you at your work? Yes No

INSURANCE INFORMATION

Primary Carrier (Health? Auto?) _____ Group Number _____
circle one

Name of insured _____ Employer _____

ID Number _____ Social Security # _____

Send Claim To _____
Street City State Zip

X_____

Signature of Responsible Party Date