7 Gran Fondo Valerio Agnoli
Fiuggi - 9 Giugno 2019

Modulo di Iscrizione Individuale

	Compilare ed inviare a, A.S.D. Valerio Agnoli C/C IT18Z0871674441000019095076 Via Cisterna Antica Traversa 3 SNC - Fiuggi

DATI ATLETA

Nome: _____ **Cognome**: _____

Data di Nascita: ___/___/_____ Età: _____ Sesso: M ____ F ____

Indirizzo:_____

Città: _____ Cap: _____ Prov.: _____Nazione: _____

Telefono fisso: _____ Mobile: _____ E-mail:_____

SSN #: _____ **Data di Nascita:** _____ Età: _____ Marital Status: M S W D

Male: ____ Female: ____ Employment Status: ( ) Full Time ( ) Part Time ( ) Retired ( ) Unemployed ( ) Student

Bill To:_____

Place of Employment: _____Title:_____

Referred by: _____ Primary Care Physician: _____

DATI SOCIETA'

Nome Società: _____

Indirizzo Società_____ Codice Società_____

Responsible Party: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work phone: _____ Cell Phone: _____

In case of emergency, please contact: Name: _____
Relationship to Patient: _____ Phone: _____

INSURANCE/ WC INFORMATION
Valid INSURANCE ID cards and a PICTURE ID need to be presented at the first visit

Prim. Insurance or WC carrier: _____ Policy #:_____

Group #: _____ Name of Insured: _____

Insured's date of birth: _____ Relationship to Patient: _____

Secondary Insurance: _____ Policy #: _____

Group #: _____ Name of Insured: _____

Insured's date of birth: _____ Relationship to Patient: _____

***** ***Please read the information and sign on other side*** *****

Il modulo va compilato in tutte le sue parti e firmato dal presidente dell'associazione di appartenenza, se il modulo non è completo l'iscrizione non è valida, l'iscrizione per essere valida,va inviato modulo compilato in tutte le sue parti, copia pagamento e copia tessera sportiva(il tutto leggibile). Nel modulo è obbligatorio inserire i dati veritieri e reali, non sono ammessi moduli che ad esempio riportano per tutti gli iscritti la stesa mail o telefono di un singolo iscritto

Dichiaro che i dati forniti corrispondono a verità, consapevole che eventuali dichiarazioni mendaci comporteranno la mia espulsione dalla manifestazione; di aver esaminato il Regolamento della manifestazione e di accettarlo integrarlmente quale disciplina del rapporto con l'organizzazione e con la KRONO SERVICE assumendo gli oneri ivi previsti, di prestare il consenso dei dati personali effettuato dall'organizzazione e dalla KRONO SERVICE in relazione alla organizzazione della presente manifestazione in conformità all'art.13 D.Lgs 30.8.2003 N.198 T.U.Privacy e modifiche successive.

HAMPTON ROADS NEUROPSYCHOLOGY

780 Lynnhaven Parkway, Suite 340 Virginia Beach, Virginia 23452
739 Thimble Shoals Blvd. Suite 704 Newport News, Virginia 23606
757.498.9585 Fax:757.468.1685 Email: HRNAdmin@thememoryclinic.com

PATIENT REGISTRATION FORM

FILING INSURANCE CLAIMS AND OBLIGATION OF PAYMENT
IT IS UNDERSTOOD BY THE UNDERSIGNED THAT: Insurance coverage is a contract between the patient and their insurance company and that charges are ultimately the responsibility of the patient /guarantor. It is understood that all co-pays, co-insurance, and deductibles are the responsibility of the patient/guarantor and that payment is required at the time services are rendered. There is a $50 fee for returned checks.

If you are covered by an insurance carrier with whom we participate, HRN will file insurance claims as a courtesy, and will provide all documentation necessary for reimbursement. Although HRN makes every effort to confirm benefits and obtain pre-authorization for services, it is not a guarantee of payment. Many insurance carriers maintain a policy of reimbursement based on medical necessity. Medical necessity is determined upon receipt and review of claims.

If the patient is not covered by insurance, if the patient is seeking treatment because of litigation-or has been referred to HRN by an attorney-or if the patient is seeking treatment for educational, competency, disability or placement purposes, commercial insurance *cannot* be filed under these circumstances and payment in full is required at the time services are rendered.

HRN is not a MEDICAID provider. If the patient has MEDICAID as a secondary to Medicare, or has no supplemental/secondary insurance to Medicare, a 20% co-insurance payment (as mandated by Medicare) is required at the time services are rendered unless payment arrangements are made in advance.

The undersigned does direct and assign payment from any insurance coverage, workman's compensation, governmental agency, disability benefit, and assignment of proceeds from all settlements, judgments or verdicts in favor of the undersigned from third party liability claims for injuries treated hereunder, in an amount equal to the full amount of charges incurred to HRN.

PAST DUE BALANCES AND COLLECTION COSTS
Any remaining balance on a patient account, after an insurance carrier or third party payor has reimbursed their contracted amount, and all attempts to collect from insurance have been exhausted, are the responsibility of the patient/guarantor and are due upon receipt of an HRN statement.
The obligation of each undersigned is an original, direct and independent promise to pay based on the exclusive credit of each and not a collateral or contingent promise to answer for that debt. I the undersigned understand that I am responsible for all collection and/or attorney fees incurred in the collection of a debt.

CANCELLATIONS / NO SHOWS
HRN requests at least 24 hours notice if, for any reason, the patient is unable to keep an appointment. Failure to contact HRN for a new patient, therapy or feedback appointment may result in a $30 fee. Failure to contact HRN for a testing appointment may result in a $150 fee. All missed appointment and no show fees must be paid prior to re-scheduling. Patients that miss or cancel two appointments may not be re-scheduled.

ACKNOWLEDGEMENTS:
I the undersigned, acknowledge, understand, and will comply with all the policies stated above.

PATIENT NAME (please print) _____

PATIENT SIGNATURE_____

PARENT/GUARDIAN/GUARANTOR (signature)_____

DATE_____