MONTEREY BAY
NEUROFEEDBACK CENTER

Training and Rebalancing the Brain ▪ montereybayneurofeedback.com

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FOR OFFICE USE ONLY:

CLIENT INFORMATION

Last Name ..... First Name .....

Address .....

City ..... State ..... Zip code .....

Home Phone ( ) ..... ☐ Male ☐ Female

Cell Phone ( ) ..... Age ..... Date of Birth .....

Work Phone ( ) ..... SSN .....

Email Address .....

I give permission to be contacted at the above phone numbers and email address. ☐ Yes ☐ No Initials .....

■ PARTNER STATUS

☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ In Relationship

Household Members .....

.....

.....

Contact person in case of emergency .....

Relationship ..... Home Phone ( ) .....

Cell Phone ( ) ..... Work Phone ( ) .....

■ REFERRAL SOURCE

Who referred you?

Name .....

Phone *(if professional)* ( ) .....

Does Dr. Vieille have permission to release information to, or consult with, your referring professional?

☐ Yes ☐ No Initials .....

■ PAYMENT INFORMATION / PAYMENT IS REQUIRED AT TIME OF SERVICE

☐ Client will pay at time of service. No insurance processing is required.

☐ Client will pay at time of service, and will complete all insurance information.
Our office will provide you with a courtesy superbill to submit to your insurance panel for reimbursement.
Please make sure the front office is aware that you are requesting a superbill, and one will be provided at the end of each month.