FINANCIAL RESPONSIBILITY FORM

FILL OUT COMPLETELY - IF INCOMPLETE, CLAIMS WILL NOT PROCESS, AND INSURED WILL BE RESPONSIBLE FOR CHARGES

PATIENT INFORMATION

Last Name: ________________________ First Name: ________________________ Middle: ____________

Date of Birth: ______________________Social Security Number: _____________________ Sex: M___F___

Marital Status: ____________

Home Address:_____________________________________ City: _____________________ Zip:_________

Home Ph: (   ) ____________________________ Cell Ph: (   ) __________________________________

Employer Name: ____________________________________Work Number: (   )____________________

INSURANCE INFORMATION (ATTACH COPY OF INSURANCE CARD FRONT AND BACK)

Primary Insurance: ____ Type of plan:____________________

Insurance Address: __________________________________City/State/Zip:__________________________

Insured Name: ____ Relation to patient: _______________

Insured Date of Birth: _____________________ Insured Social Security Number: _____________________

ID#:________________________________ Group #:________________ Effective Date: _______________

Insurance Ph #: (   )________________________ Employer: ____________________________________

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Secondary Insurance: _______________________________________ Type of plan:___________________

Insurance Address: __________________________________City/State/Zip:__________________________

Insured Name: ____Relation to patient: ________________

Insured Date of Birth: ______________________Insured Social Security Number: _____________________

ID#:________________________________ Group #:_________________Effective Date: _______________

Insurance Phone #: (   )______________________Employer: ____________________________________

I, ____, certify that I have insurance coverage with _______________________________________ insurance company(ies) and assign directly to *The Clinic Neuropsychological & Psychological Services, PLLC*, all insurance benefits, if any, otherwise payable by me for services rendered. I understand that I am financially responsible for all charges whether paid by the insurance or not. I hereby authorize the doctor/clinician to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

________________________________	_______________________	______________________
SIGNATURE OF RESPONSIBLE PARTY	**RELATIONSHIP**	**DATE SIGNED**

PATIENT FINANCIAL AGREEMENT

CONFIDENTIALITY: I understand that my records are confidential and will not be released to outside individuals of agencies without written consent. However certain information may be released without my authorization under the following circumstances:

1. In the event of a medical emergency.
2. If there is evidence of child abuse, dependent or elder abuse.
3. When a hazard to the public requires disclosure.
4. When there is an indication that I will likely harm myself.

TELEPHONE CONSULTATIONS: I understand that telephone consultations are not covered by Medicare and other health plans. Therefore, I understand that telephone contacts beyond appointment scheduling may result in a charge equivalent of $200.00 per hour for the duration of call. *The Clinic* does provide a free 10-15 minute consult prior to scheduling, but after scheduling, the rate applies.

FINANCIAL RESPONSIBILITY: I understand that I am responsible for obtaining all necessary referrals prior to scheduling an appointment for neuropsychological/psychological testing. All co-pays required by my Insurance Plan will be paid at the time of service. I further acknowledge that all deductibles, co-insurance, and non-covered items as determined by my insurance plan will be due and payable upon notice either sent by US Mail in the form of a statement and/or communication from *The Clinic Neuropsychological & Psychological Services, PLLC*. Any balances not paid within 30 days from the day the statement is sent will result in an additional $12.00 fee.

CANCELLATIONS: Appointments are regarded as contract for the exclusive use of the doctor's time. I understand that regular charges may be applied to missed appointments without 72 business hours advance cancellation notice. I understand that my insurance carrier will not pay for my absence and I will be responsible for these charges. Excessive cancellations will require a credit card on file before any further scheduling can proceed. No shows/ late cancellation will result in a $75 fee.

FINANCIAL ESTIMATE: Out of pocket estimate for some Insurance providers can range from $600-$4,000.

Signature:____ Date:______________________

(I understand my financial and business agreements listed on the previous two pages)

PAYMENT OPTION:

I AUTHORIZE MY CREDIT CARD TO BE BILLED FOR ANY AND ALL OUT-OF-POCKET CHARGES THAT MAY BE INCURRED.

VISA / MASTERCARD / Discover / American Express (circle one)

Card #____

EXPIRATION: ____________________ CVV # ________________ Billing Zip Code ________________

SIGNATURE: ____ Date:__________________

A valid credit card on file is mandatory with proceeding.