Compassionate Neuropsychology, LLC

By signing below, I acknowledge and consent to the following:

* I have consented to assessment provided by COMPASSIONATE NEUROPSYCHOLOGY, LLC, and its employees. I authorize the services deemed necessary or advisable by COMPASSIONATE NEUROPSYCHOLOGY, LLC to address my needs.
* If I have provided COMPASSIONATE NEUROPSYCHOLOGY, LLC with insurance billing information, I understand as a courtesy to me that they will bill my insurance carrier(s) directly.

**ACKNOWLEDGEMENT & FINANCIAL AGREEMENT**

* If I have provided COMPASSIONATE NEUROPSYCHOLOGY, LLC, with insurance billing information, I authorize and request that my insurance plan(s) pay directly to COMPASSIONATE NEUROPSYCHOLOGY, LLC the amount due for services rendered that are covered under the plan(s). I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services rendered until full payment is received.
* I agree to take full responsibility for the entire amount due for any and all services rendered. If COMPASSIONATE NEUROPSYCHOLOGY, LLC is contracted with my insurance carrier(s), I understand and agree that I am responsible for all co-pays, co-insurance, deductibles, and non-covered services as determined by the insurance plan(s).
* I understand that if a referral or prior authorization is required for services that I will be responsible for obtaining the appropriate referral or authorization for services. I further acknowledge that if a referral or prior authorization is not obtained prior to the date of services that I am responsible for the full amount of the services at the time of service.
* I acknowledge that authorization by my insurance plan(s) does not guarantee payment by the insurance carrier(s), and that if the carrier(s) denies payment for the services that I am responsible for payment of all charges.
* I agree that if I do not advise COMPASSIONATE NEUROPSYCHOLOGY, LLC, about a change in my insurance coverage that I may be responsible for the full charges of services that occurred if payment is denied in part or full by my insurance carrier(s).

I have read the policy described above and accept the conditions set forth.

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Print Patient Name

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Signature of Patient or Financially Responsible Party

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Date