Neuropsychology Associates, Inc.
Child, Adolescent, and Adult Neuropsychologists

Acknowledgement of Receipt of our Financial Agreements and Practice Policies

I, the patient/legal guardian, consent to examination, assessment, and treatment protocols by Neuropsychology Associates as deemed medically appropriate.

This consent to treat shall remain in effect until treatment protocols are concluded, the patient is discharged from the services of Neuropsychology Associates, or upon the practice's receipt of written notification regarding the intent to terminate treatment.

I am responsible for payment of services the day provided, unless otherwise specified by the practice.

I agree to have a credit card number kept on file with Neuropsychology Associates, which will be charged for any outstanding balances at least 30 days overdue.

If my insurance company fails to pay for some or all services rendered, I will be responsible for the balance, as well as for any copays.

Failure to notify Neuropsychology Associates of the need to cancel or reschedule an appointment within 3 days of the scheduled appointment may result in a cancelation fee being charged to the credit card on file.

_____
Signature of Patient, Parent or Guardian

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Print Name of Patient, Parent or Guardian

_____
Date

_____
Designate if Signed by Patient, Parent or Guardian