Neuropsychology Partners Practice Financial Policy

In regards to the fee for the service(s) we will be rendering, we will assist you with a courtesy billing to the primary insurance carrier and any available secondary carrier (s). However, we would like to advise you that **you are responsible for payment for the services rendered.** If we have not secured payment from your insurance company within 90 days, you will be responsible for the bill.

In order to provide the courtesy billing, we need your assistance in providing full and complete information in regards to your health insurance policy and any secondary insurance plan(s) that might be applicable. If we are a non-participating facility with your insurance plan, you may receive all information, such as Explanation of Benefits, and all payments. We need your cooperation in promptly providing our office with originals or copies of any payment, correspondence, rejection notices, etc. that you receive from your insurance carrier(s). We will be happy to provide you with a stamped, addressed envelope for this purpose.

Because insurance plans and benefits vary greatly by individual plan and employer, **we do not quote specific insurance benefits.** As the insured, you are ultimately responsible to know your copay and deductible information. We are more than happy to provide you with the procedure codes we use for billing so that you may contact your insurance company for detailed benefit information.

Additionally, as the insured, you are responsible for knowing if Neuropsychology Partners is in-network with your insurance. We participate with a wide range of insurance plans, however, we do not participate with any Medicaid plans. If you have one of these insurances as primary or secondary, you will be responsible for any copays, deductibles, or balances associated with your visits.

FINANCIAL RESPONSIBILITY STATEMENT:

I understand that the charges for services received may exceed the benefits payable or may not be a covered benefit under my present health insurance plan. I also understand that my cooperation is required in providing Neuropsychology Partners with any and all payments, and copies of the Explanation of Benefits, which accompanies the payment or any notice of rejection of payment. I agree to accept responsibility for providing the necessary paperwork, or copies thereof to secure payment for services rendered.

Additionally, I understand that Neuropsychology Partners has a **48 hour cancellation policy** for all scheduled appointments. We reserve the right to charge a no show/late cancellation fee for appointments that are not cancelled 48 hours prior to the scheduled appointment time. No show/late cancellation fees are as follows:

Psychological or Neuropsychological testing - $150

No appointments will be rescheduled until this fee has been paid or payment arrangements have been made. These late cancellation fees are non-refundable and are not payable by your insurance carrier.

Co-payments are due at the time of the visit, unless other arrangements have been made. There is a $30.00 fee for all returned checks. If your account is 90 days delinquent, services may be discontinued and your account turned over to a collection agency. Additional fees may be assessed for medical records requests and form completion.

I understand and agree to all of the conditions listed above. I agree to accept financial responsibility for payment in full or for any balance remaining after insurance payments has been made to Neuropsychology Partners.

_____ _____

Signature Date

_____ _____

Neuropsychology Partners Employee Date