Mt. Diablo Memory Center Inc.

STATEMENT OF FINANCIAL RESPONSIBILITY

Please read and sign this form that outlines financial responsibility for treatment.

1. The patient/guardian is financially responsible for services received. You are responsible for informing us of any changes to your insurance coverage.

2. The financial responsibility can be met if insurance benefits cover services rendered. Covered services vary by insurance plan; it is your responsibility to understand the benefits and requirements of your specific plan. You may be required to obtain pre-authorization and/or a physician referral; denial by your insurance company due to lack of these are your responsibility. You may be required to pay a portion of fees due to a deductible or co-payment as dictated by your insurance. You agree to assign any monies due and payable by the insurance company for these services to our facility. A copy of your charges, if requested, will be supplied to you so that you may follow up with your insurance company personally.

3. Payment by your insurance company is often subject to an evaluation for medical necessity as determined by your insurance company. Services specifically requested for or related to a job, education or legal proceedings may not be covered.

4. If you choose to use insurance benefits to pay for services, we will be required to provide information to the insurance company. This is likely to include diagnoses, symptoms and treatment plan, though other information may be required. Once information leaves our office we cannot control how it is used. If you choose not to share information with your insurance company, you may not receive reimbursement for the services you are receiving.

5. Payment is expected at time of service unless specific arrangements are agreed upon in advance. We are willing to work with you to set up a payment plan for any amounts not paid by your insurance. Finance charges of 1.5% will be charged each month for unpaid balances over 30 days (18% annual percentage rate). If a balance remains unpaid for an additional 30 days, your account may be referred to a collection agency. Any fees for additional collections will be added to your balance due.

6. If you request copies of information sent to another source or if you have given another source permission to review evaluations or other reports, there may be a charge for copying and mailing. If letters are written on your behalf, or extended or frequent telephone calls or e-mails made, additional hourly rates for services may apply for time over 10 minutes. Hourly rates are $250/hour for assessment and $150/hour for treatment.

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7. A minimum of 48 hours' notice is required for cancellation of appointments as we set aside a substantial block of time for your evaluation. If this notice is not received, you may be charged for the full cost of the missed appointment. Insurance will not be billed for cancelled/missed appointments.

8. We will file a claim with your insurance as a courtesy to you; we do not guarantee that service will be covered or at what percentage it may be covered. Insurance typically pays 50%-80% of our services if deemed medically necessary. Co-payments, deductibles, and non-covered services are payable at time of service.

9. Neuropsychological evaluation and testing includes time for administering and scoring tests, clinical interview, interpretation of data, review of records, conferring with other providers/parties, preparing reports and discussion of the results. All of these aspects typically add 1-6 hours to the actual testing time that you spend in our clinic.

10. We are participating providers with Medicare, which means that we accept Medicare assignments as payment in full, once your deductibles and co-payments have been made. We will bill Medicare for you, as well as your supplemental insurance carrier. You must provide valid cards from Medicare and other insurance carriers. Without these we cannot bill, and payment will be expected at the time of your visit.

11. For your convenience, we accept cash, checks and credit cards. Please make your check payable to Mt. Diablo Memory Center. A $25 charge will apply on all returned checks.

Patient Signature: _____ Date: _____

Parent/Responsible Party Signature: _____ Date: _____
(If patient is a minor or otherwise unable to sign for his/herself)