Falls Neuropsychology and Psychotherapy Associates, PLLC

ACKNOWLEDGEMENTS AND CONSENTS

I have received from Falls Neuropsychology and Psychotherapy Associates, PLLC, "Notice of Privacy Practices" and had adequate opportunity to read and review this document.

Signature: _____ Date: _____

I agree to receive treatment from Falls Neuropsychology and Psychotherapy Associates, PLLC. I understand I can withdraw this consent for treatment at any time.

Signature: _____ Date: _____

I authorize Falls Neuropsychology and Psychotherapy Associates, PLLC to leave messages for me either on a voicemail/ answering machine or with a person in my home.

Signature: _____ Date: _____

In order that we may file your insurance for you, please read and initial each line and sign the following signature-on-file form.

___ I authorize use of this form on all my insurance submissions.
___ I authorize release of information to all my insurance carriers.
___ I understand that I am responsible for my bill.
___ I authorize my provider to act as my agent in helping me obtain payment from my insurance carriers.
___ I authorize payment directly to my provider and hereby assign my right to reimbursement for services rendered to Falls Neuropsychology and Psychotherapy Associates, PLLC.
___ I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____

I have been provided access to a copy of the Policies and Procedures and my provider has reviewed relevant Policies and Procedures including the need for 24 hour cancellation notice to avoid a cancellation charge and of the differences between therapeutic, evaluation, and forensic services. I agree to these policies and my preference for payment is as follows:

___ Pay each visit in full (and file my own insurance for possible reimbursement)
___ Pay my insurance co-payment and other fees each session (or utilize my EAP benefit) and have my insurance filed for me.
___ Make an alternate payment plan that must be specific and receive prior approval from the managing members of Falls Neuropsychology and Psychotherapy Associates, PLLC.

Signature: _____ Date: _____

Clinician's Signature (as witness) & date: _____