NEUROPSYCHOLOGY ASSOCIATES OF FAIRFAX VIRGINIA, LLC

BY SIGNING BELOW, I AM ACCEPTING THE TERMS OF SERVICES AND OFFICE POLICY AS FOLLOWS:

I UNDERSTAND THAT FEES FOR SERVICES ARE BILLED BY A PER HOURLY RATE OF $ 275.00 PER HOUR. BILLING FOR NEURO-COGNITIVE AND PSYCHOLOGICAL TESTING INCLUDES ALL HOURS OF ACTUAL TESTING (THIS MAY BE DONE BY A TECHNICIAN), INTERVIEWING, SCORING, RESEARCH, INTERPRETATION AND PREPARATION OF THE REPORT AND YOUR FEEDBACK CONFERENCE(S).

YOUR INSURANCE PLAN DOES NOT COVER ANY SERVICES THAT ARE RELATED TO LEARNING DEVELOPMENTAL PROBLEMS OR EDUCATIONAL ISSUES, TESTING MAY INCLUDE OR BE FOR THESE REASONS. YOU AGREE TO BE RESPONSIBLE FOR THESE CHARGES. _____(INTIALS)

INSURANCES DO NOT PROVIDE COVERAGE FOR NPT FOR EMPLOYMENT, DISABILITY QUALIFICATION, LEGAL AND OR COURT RELATED PURPOSES. YOU AGREE TO BE RESPONSIBLE FOR THESE CHARGES. NO CLAIMS ARE FILED TO INSURANCE: _____ (INITIALS)

ADDITIONAL SERVICES SUCH AS TELEPHONE CONSULTATIONS, LETTERS, ADDITIONAL REPORTS, MISSED APPOINTMENTS, AND OTHER FEES WILL BE BILLED AT A PRO-RATE OF TIME USED BASED ON $ 275.00 PER HOUR. _____**(INITIALS)**

FORENSIC EVALUATIONS, LEGAL REPORTS, TESTIMONY AND TRAVEL TIME ARE BILLED AT $500 PER HOUR BASED ON THE SERVICE REQUESTED. _____**(INITIALS)**

We are contracted to CareFirst, Aetna, Kaiser Permanente, and Medicare.

WE DO NOT HAVE A CONTRACTUAL RELATIONSHIP WITH ANY OTHER INSURANCE CARRIER. AS A COURTESY, OUR OFFICE WILL PREPARE AND SUBMIT YOUR INSURANCE CLAIM. SUBMISSION BY THIS OFFICE OF INSURANCE CLAIMS FOR SERVICES RENDERED DOES NOT WAIVE YOUR RESPONSIBILITY FOR THE FEES INCURRED. OUR OFFICE FILES INSURANCE CLAIMS AS A COURTESY; ALL FOLLOW UP IS THE RESPONSIBILTY OF THE INSURANCE SUBSCRIBER. PLEASE CONSULT WITH YOUR INSURANCE CARRIER TO DETERMINE WHAT SERVICES WILL BE COVERED UNDER YOUR PATICULAR PLAN. BY SIGNING BELOW, YOU AGREE TO INDEMNIFY OUR OFFICE FROM ANY ERROR OR OMISSION IN THE PREPARATION OR FILING OF YOUR INSURANCE CLAIM. IT IS YOUR RESPONSIBILITY TO MAKE SURE THAT INSURANCE CLAIMS HAVE BEEN FILED AND ARE COMPLETE. _____ **(INITIALS)**

IF YOU WOULD LIKE US TO FILE A CLAIM IN YOUR BEHALF, PLEASE COMPLETE THE INSURANCE INTAKE FORM COMPLETELY.

UNLESS OTHERWISE AGREED TO IN WRITING, I UNDERSTAND THAT ACCOUNTS ARE DUE ON RECEIPT. INTEREST AT A RATE OF 1.5% PER MONTH WILL BE CHARGED TO ANY ACCOUNTS 90 DAYS PAST DUE. IF THIS ACCOUNT IS REFERRED TO ANY AGENCY OR ATTORNEY FOR COLLECTION PROCEEDINGS, I WILL PAY ALL COSTS INCURRED IN THE COLLECTION OF THIS ACCOUNT INCLUDING BUT NOT LIMITED TO ATTORNEY'S FEES IN THE AMOUNT OF 50% OF YOUR ACCOUNT BALANCE AT THE TIME THE ACCOUNT IS PLACED. I UNDERSTAND AND AGREE THAT EDUCATIONAL SERVICES ARE NOT BILLABLE TO MY INSURANCE AND I WILL BE RESPONSIBLE FOR THOSE CHARGES INCURRED.

SIGNATURE DATE PRINT PATIENT'S NAME

RELEASE TO FILE INSURANCE CLAIM:

NEUROPSYCHOLOGY ASSOCIATES OF FAIRFAX VIRGINIA IS AUTHORIZED TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED TO ME BY SAME, UNDER MY INSURANCE PLAN. I REQUEST PAYMENT FROM MY INSURANCE CARRIER BE MADE DIRECTLY TO NEUROPSYCHOLOGY ASSOCIATES OF FAIRFAX VIRGINIA. NEUROPSYCHOLOGY ASSOCIATES OF FAIRFAX VIRGINIA IS FURTHER AUTHORIZED TO RELEASE ANY NECESSARY INFORMATION, INCLUDING MEDICAL INFORMATION, TO MY INSURANCE COMPANY IN ORDER TO DETERMINE BENEFITS TO WHICH I AM ENTITLED.

THIS AUTHORIZATION TO RELEASE INFORMATION MAY BE REVOKED IN WRITING.

X

SIGNATURE DATE PRINT PATIENT'S NAME

OR, **I do not want a claim filed to my carrier.**

X

SIGNATURE DATE PRINT PATIENT'S NAME

IMPORTANT, PLEASE READ -

Lawsuits and Other Legal Proceedings: We may use or disclose PHI when required by a court or administrative tribunal order. We may also disclose PHI in response to subpoenas, discovery requests, or other required legal process when efforts have been made to advise you of the request or to obtain an order protecting the information requested.
If testing is contracted by patient's legal counsel, worker's compensation, and/or opposing legal entities, all work product is the property of the contracting entity. Our office does not represent the client tested nor makes any promises as to findings or outcomes. Patient does not have the right to restrict the release of work product. _____**(INITIALS)**

MEDICARE AND GOVERNMENT INSURANCES – PLEASE READ AND SIGN:

UNDER SECTION 1862(b)(2) OF THE SOCIAL SECURITY ACT, I CONFIRM THAT THESE SERVICES ARE NOT THE RESULT OF AN ACCIDENT IN WHICH ANOTHER LIABLE INSURANCE MAY BE RESPONSIBLE TO PAY. I FURTHER ATTEST THAT THESE CHARGES WILL NOT BECOME PART OF A LAWSUIT AGAINST ANOTHER LIABLE PARTY.

X

SIGNATURE DATE PRINT PATIENT'S NAME

NEUROPSYCHOLOGICAL TESTING USES TESTING MATERIALS THAT ARE PROPRIATARY/COPYRIGHTED AND PROTECTED BY ETHICS STANDARDS TO MAINTAIN TEST INTEGRITY. RAW DATA AND TESTING MATERIALS CAN NOT BE RELEASED TO ANYONE OTHER THAN ANOTHER LICENSED NEUROPSYCHOLOGIST, YOUR SIGNATURE ACCEPTS THESE STANDARDS.

X

SIGNATURE DATE PRINT PATIENT'S NAME

NEUROPSYCHOLOGY ASSOCIATES OF FAIRFAX VIRGINIA follow HIPAA guidelines. Please sign below that you have either received (or have declined) a copy of the office policy.

X

SIGNATURE DATE PRINT PATIENT'S NAME

ANY ALTERATIONS TO THIS CONTRACT NOT MADE BY MUTUAL CONSENT ARE UNENFORCEABLE _____ (INITIALS)