

## Notice of Privacy Practices for Protected Health Information

Neuropsych is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operation. A copy of the Privacy Practices is available for your review in our front office.

- Neuropsych requires your authorization to use an automated telephone system and/or email in order to notify you of a pending appointment or related health care communication. The information that may be included is the name of your scheduled treating provider and the time and place of your appointment.
- Neuropsych requires your authorization to disclose to third parties who may answer your phone(s), limited protected health information regarding pending appointments and to leave a reminder message on your voicemail or answering machine.

Your signature below indicates that you have reviewed this information and authorized us to contact you at the number indicated below:

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Print Name

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Authorized Telephone #

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Signature of Patient/Patient Representative

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/ /  
Date

## Neuropsych Financial Policy

- Full Payment is due at time of services unless Neuropsych participates in your insurance plan. If we participate in your health care plan, Neuropsych will be responsible for billing your insurance company.
- We will only bill insurance companies with whom we have in-network status. For all other plans it is the patient's responsibility to submit bills to the insurance company after paying the balance in full at Neuropsych.
- **Missed appointments will be billed in full to the patient unless canceled by 3:00 pm the prior business day. We are unable to bill your insurance company for charges incurred by missed appointments. The credit card that we have on file may be billed for the entire cost of the session missed.**
- Patients receiving medication must be seen for regular appointments at intervals agreed upon with their physician. The physician will provide you with the correct amount of medication to last until your next designated appointment. If circumstances arise that you miss this appointment or lose your prescription, and refills are required, you may be charged a fee for a phone refill.
- There will be a \$30 fee on all returned checks.

I understand and agree to this financial policy.

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Signature of Responsible Party

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/ /  
Date