Neuropsychological Consultants, Inc.
5017 Green Bay Rd., Suite 130
Kenosha, WI 53144
(262) 672-1334
Teresa M. Deer, Ph.D. June A. Restrepo, Ph.D., ABPP-Cn

Patient:_____

Dr. Deer and Dr. Restrepo of *Neuropsychological Consultants, Inc.*, are Medicare providers. *Neuropsychological Consultants, Inc.* will bill Medicare for the services provided to you today. Medicare will pay 80% of their "Usual and Customary" fee allowance for these services. You will be responsible for paying office visit co-payments, annual deductible amounts, and the 20% co-insurance balance.

If you have Medicare Supplemental or Secondary insurance, *Neuropsychological Consultants, Inc.* will bill that policy for the 20% co-insurance amount. *Neuropsychological Consultants, Inc.* cannot guarantee that your Supplemental or Secondary insurance company will pay for the services provided to you today. If, after reasonable attempts to obtain the co-insurance payment have been exhausted, your Supplemental or Secondary insurance company refuses to pay, you will be required to pay the remaining unpaid balance amount. If necessary, a minimum monthly payment plan can be arranged between *Neuropsychological Consultants, Inc.* and you to allow for payment over a defined period of time.

NOTE: Dr. Deer and Dr. Restrepo are not providers in certain Medicare HMO programs. For services provided to individuals in such Medicare HMO plans, the insured individual will be responsible for payment of all applicable charges. *Neuropsychological Consultants, Inc.* will provide the necessary documentation to allow the individual to attempt to recoup payment from the HMO for services rendered.

By signing this form, you are indicating that you have read & understood all of the information provided above, and agree to abide by it.

Neuropsychological Consultants, Inc._____

By signing below, I indicate that I have read and that I understand the statements above, and agree to abide by them. I understand that I will be responsible for any Medicare co-insurance charges not covered by my Supplemental or Secondary insurance company.

_____

Patient's Signature Date

_____

Guardian or legally responsible person's signature Date

_____ Note: if Guardian or POA for Healthcare, a

Relationship to patient copy of the legal document indicating this must be attached.