Neuropsychological Consultants, Inc.
Teresa M. Deer, Ph.D. June A. Restrepo, Ph.D., ABPP-Cn
(262) 672-1334

Patient:_____

Teresa M. Deer, Ph.D. and June A. Restrepo, Ph.D., of *Neuropsychological Consultants, Inc.*, are **NOT** a participating provider in the _____ health care insurance network. You are therefore required to make an initial payment in the amount of $100.00 on the day of your visit with your doctor.

As a convenience to you, *Neuropsychological Consultants, Inc.* will bill your insurance for the services provided to you, and will indicate your initial payment today. After your health care insurance company has paid its portion, you will be responsible for paying any and all remaining balance.

Neuropsychological Consultants, Inc. cannot guarantee that your health care insurance company will pay any amount for the services provided to you today. If, after all reasonable attempts to obtain payment have been exhausted and your health care insurance company refuses to pay for these services for any reason, you will be responsible for payment in full for all charges related to the services provided to you by your doctor. 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.

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 charges not covered by my insurance company.

_____

Patient's Signature Date

_____

Guardian or legally responsible person's signature Date

_____

Relationship to patient

Note: if Guardian or POA for Healthcare, a copy of the legal document indicating this must be attached.