dr. taylor

NEUROPSYCHOLOGY

Payment for Services

Payment for requested services is due on or before the date services are rendered, as described in our financial agreement. If you would like, we will contact your insurance company to inquire about your out-of-network benefits and to submit your claim. We will estimate your co-payment based on the information provided by your insurance company, including their statements regarding your deductible, co-insurance, and coverage. Please be aware that there is no guarantee that your insurance company will cover the service(s), even if they initially say they will do so.

It has been our experience that insurance companies sometimes deny or reduce coverage based on the terms of a particular plan, diagnosis, or the company's beliefs about whether the service is medically necessary. Such opinions may differ from your beliefs or those of the referring physician.

If you would like for us to contact your insurance company to inquire about benefits and/or to file your claim, please provide the following information:

Insurance Company: _____

Phone:_____

Address: _____

City: _____ State:_____ Zip Code:_____

Name of Insured: _____

Insured's Employer: _____

Member/Policy Number: _____

Group Number:_____

I have provided the most accurate and up-to-date information available and understand the above statements regarding insurance coverage and would like to proceed with the requested services.

Signature: _____ Date: _____