dr.taylor

NEUROPSYCHOLOGY

Consent for Treatment - Adult

I give my consent to receive psychological and/or neuropsychological services from Shannon E. Taylor, PhD and the staff members of Dr. Taylor's office.

I understand that services are provided on a confidential basis and records are disclosed only when properly authorized.

I understand that payment for services are due at the time of service, and that my appointment will need to be rescheduled if I am unable to fulfill this obligation.

I understand that if I cancel my appointment with less than 24 hours notice, or if I do not arrive for a scheduled appointment, any future appointments made will need advance payment before being scheduled.

I give consent for the staff of Dr. Taylor's office to contact my insurance company, if applicable to obtain information regarding my insurance benefits for the requested services.

I understand that this contact is provided as a courtesy to me, and that the decision to reimburse me for the services provided rests fully at the discretion of my insurance company.

I understand that I am responsible for the full cost of services provided, and that my insurance company's agreement to reimburse me for any services rendered is an issue between my insurance provider and myself.

Signature: ____ Date: ____________________________

If signed by a guardian, please state legal basis for guardian status:____________________________

Receipt of HIPAA Disclosure

I hereby acknowledge that I have received a copy of the HIPAA Disclosure Form utilized by Dr. Taylor's office.

Signature: ____ Date: ____________________________