dr.taylor

NEUROPSYCHOLOGY

Consent for Treatment– HIPPA

I give my consent for my child 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 child's 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.

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

Signature of Parent or Legal Guardian: ______________________________ Date: ________________

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