NEUROBLOOM
PSYCHOLOGICAL CLINIC

FINANCIAL AGREEMENT

Client's Name:_____ **Date of Birth:** _____

We urge you to contact your insurance company to verify your specific insurance benefits.

If we are billing insurance for your visit, we must have completed information at the time of this visit. If you cannot provide the information, we will be unable to bill your insurance, and the payment in full will be required.

Your charges for our services cannot be determined until the claim is submitted to your insurance company. Prior to receiving an Explanation of Benefits (EOB) from your insurance company, we will doour best to estimate your plan deductible, co-pay and/or co-insurance. All payments are due at the time of the service.

For any balance left unpaid or not responded to , Neurobloom Psychological Clinic (NPC) reserves the right to use an outside collection agency as a means of collecting funds. A fee will be charged to cover this service.

I understand that I will be charged a $35 fee for any returned check.

I understand it is my responsibility to keep arranged appointment times or to cancel an appointment at least 48 hours prior to the appointment to avoid a missed appointment fee being charged. This fee is to at the next appointment and cannot be billed to your insurance company.

I give Neurobloom Psychological Clinic (NPC) permission to bill my insurance company.

By signing below, I agree to comply with the policies and procedures of NPC

_____ _____

(Client/Parent/Guardian Signature) Date (Witness) Date