childneuropsychology pc
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Acknowledgement of Receipt of Privacy Practices

I have received a copy or been given the option of receiving the Child Neuropsychology PC *Notice of Privacy Practices* with an effective date of January 1, 2019.

Acknowledgement of Insurance Practices

I understand that Child Neuropsychology PC **DOES NOT** bill or accept insurance payments directly as payment for services and I accept full responsibility for payment for all services rendered by Child Neuropsychology PC. If reimbursement for services is available through my insurance carrier it is my responsibility to be familiar with and to meet all conditions specified, since the contract for any such reimbursement is between my insurer and me. Should I submit a claim before my balance is paid in full, I understand that my carrier may disperse benefits directly to Child Neuropsychology PC in accordance with Oregon law. Child Neuropsychology PC will refund any monies received that exceed my account balance.

Acknowledgement of Email Practices

I understand that Child Neuropsychology PC cannot ensure the privacy of any communication that occurs through electronic transmission (e.g., email, text messaging). Any communication that occurs through email or similar technology will be done at my initiation or with my direct permission and with the understanding that I assume full responsibility for any associated risks to privacy. By providing my email address below, I agree to receive correspondence from Child Neuropsychology PC.

Name and Address of Parents/Guardians

_____

_____

_____

Email address: _____

Email address: _____

Signature of Parents
Or Guardian _____

Printed Names _____ **Date** _____

Name / Signature of Witness _____ **Date** _____