childneuropsychology pc
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www.childneuropsychologypc.com

Acknowledgement of Receipt of Privacy Practices

I have received a copy of Child Neuropsychology PC *Notice of Privacy Practices* with an effective date of July 1, 2009.

Acknowledgement of Insurance Practices

I understand that Child Neuropsychology PC **DOES NOT** bill for or accept insurance payments directly. I understand that I am responsible for the direct payment of all services received from 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 reimbursement is between my insurer and me.

Name and Address of Patient and Guardians

Signature of Parent
Or Guardian _____

Printed Name _____ **Date** _____

Signature of Witness _____

Name of Witness _____ **Date** _____