Liana Peña Morgens, Ph.D.
Clinical Neuropsychologist

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# Financial Information Form

## CLIENT INFORMATION

Patient Name _____ Soc. Sec.#: _____ DOB: _____

Sex: M F Marital Status: S M W D LS Adopted: Y N

US Citizen: Y N Ethnicity: _____ Race: _____

Occupation: _____ Education: _____ Living with: _____

## GUARANTOR INFORMATION

Financially Responsible Party (Guarantor)_____ Soc. Sec.#: _____

Relationship of Above Patient _____ Guarantor Employer: _____

Guarantor Home Phone Number: _____ Guarantor Work Phone Number: _____

Guarantor/Billing Address _____

## INSURANCE INFORMATION

| | Primary Insurance | Secondary Insurance |
|---|---|---|
| Insurance Co. Name | | |
| Insurance Co. Address | | |
| Insurance Co. Phone Number | | |
| Subscriber Name | | |
| Certificate / Policy Number | | |
| Group Number | | |
| Effective Date | | |
| Group Name (Employer) | | |
| Address (Employer) | | |

## Benefits/Limitations (If known)

Amount of Deductible
Percent of Payment
Yearly Maximum

## SCHOOL INFORMATION

School: _____ Address: _____

Contact Person: _____ Phone #: _____

SPED Director: _____ Phone #: _____

Date _____ Signature _____

**Please be sure that both pages are signed and dated on the bottom.**

## ASSIGNMENT OF BENEFITS

In consideration of care provided I, as subscriber or insured, assign Liana Peña Morgens, Ph.D., all medical insurance benefits applicable and instruct the insurance company or companies or third party programs (e.g., school system) to make payment directly to Liana Peña Morgens, Ph.D. I understand that I am financially responsible for all charges, co-payments and deductibles remaining after insurance payments, and all charges not covered by my insurance or third party payer.

**Initial _____**

## RELEASE ON INFORMATION TO INSURANCE CARRIERS

I authorize Liana Peña Morgens, Ph.D. to furnish the above-named insurance carrier(s) or third party payers (e.g., school system) with whatever information it deems necessary concerning said care, treatment, or evaluation of the above-named person, including photocopies of the medical records which may contain information regrading all treatment, including alcohol and drug abuse treatment.

This consent will expire on _____, or one year from the final date of services. I understand that I may revoke this consent for release of information at any time except to the extent that action has been taken in reliance upon this consent. This is not revocable if treatment has been provided unless arrangements are made by you to pay for your treatment/evaluation privately to the satisfaction of Liana Peña Morgens, Ph.D.

I understand that records which contain information regrading alcohol or drug abuse treatment are protected by Federal Regulation 42CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records.

**Initial _____**

## RELEASE OF INFORMATION TO SCHOOL

I understand that as part of the agreement to have share payment, in part or in total, with the above-named school system, I authorize Liana Peña Morgens, Ph.D. to furnish the school special education department with feedback regarding the treatment/evaluation which may include a final written report.

**Initial _____**

## FINANCIAL AGREEMENT

I agree to pay all charges incurred for the above named person patient at the rates established. I understand the rates are subject to substitution and increase from time to time, and I agree to pay charges based on such substituted or increased rates. Evaluation rates, however, remain the same as the initial contracted price, and ½ of the contracted rate is due at the time of testing and the remaining balance is due upon conclusion of the final testing session.

**Delinquency Charge**

Statements are presented monthly and are payable when rendered. Payments are to be made to Liana Peña Morgens, Ph.D. A delinquency charge at a rate of 1.5% per month on the unpaid balance shall be charged on all accounts in default. An account in default is one which the uninsured or self-pay balance is due and unpaid on the 32nd date next following the date of bill. A delinquency charge shall begin to accrue when the account is in default. In those rare cases where there is a default in the obligations of this agreement, it is understood that the person indebted will be liable for all costs of collection, including reasonable attorney's fees.

Date _____ Signature _____

**Please be sure that both pages are signed and dated on the bottom.**