FINANCIAL RESPONSIBILITY AGREEMENT

Please Complete and Bring to Your First Appointment.
Please Bring Your Insurance Cards with You.
You are Responsible for Notifying our Office of any Change in Your Insurance.

VALLEY NEUROPSYCHOLOGY GROUP
VALLEY PSYCHOLOGICAL ASSOCIATES
1045 S. Cedar Crest Blvd., Allentown, PA 18103-5443
610-433-3360

Patient's Name: ____ DOB:______________________

Street Address: ____

City, State & Zip Code: ___________________________ Social Security No:__________________

Home Telephone Number: ________________ Work: ________________ Cell: ________________

Marital Status (S,M,D,W,Sep): ____Spouse's Name: ______________ Spouse's SSN: _______________

Person Responsible for Payment: ____

Primary Insurance Company Name: ________________________Phone Number: _______________

Insurance Company Address: ____

Insured's Name and Address: ____

Insured's Date of Birth: ______________________ Insured's Telephone No: ___________________

Insured's I.D. No: ___________________________ Insured's Group No: ____________________

Patient's Relationship to Insured: ____

Secondary Insurance Company Name: ______________________Phone Number: _______________

Insurance Company Address: ____

Insured's Name and Address: ____

Insured's Date of Birth: ______________________ Insured's Telephone No: ___________________

Insured's I.D. No: ___________________________Insured's Group No: _____________________

Patient's Relationship to Insured: ____

As advocates for our patients, we will make every effort to access the maximum benefits allowed under your third party payer contract ("insurance"). It is important that you understand that your benefits contract may have an "allowable amount" for each procedure, and may deny coverage entirely. You are then responsible for payment of the balance due, which may include your deductible (if not already satisfied), the co-payment, and any remaining portion of the bill that is not covered. Financial responsibility for services you receive at the office is yours alone. Thank you for your confidence in our office. We look forward to providing you with excellent care and service.

I HAVE READ THE ABOVE STATEMENT AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CARE AND SERVICES PROVIDED TO ME AND/OR MY DEPENDENTS.

Name of Responsible Party: ____________________________ Relationship to Patient: ____________

Signature: _______________________________________ Date: ___________________________