



Neuropsychological Associates

1260 North Dutton Ave, Ste 225, Santa Rosa, CA 95401

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Consent for Neuropsychological Evaluation

I understand that I am being seen for a neuropsychological evaluation. The evaluation will include an interview, medical/psychological/forensic/ educational/employment record review, and testing with various measures of attention, motivation, motor and sensory abilities, language and spatial skills, problem solving, memory, intellectual functioning, and emotional or personality functioning. I may request further information about any of these procedures.

This evaluation may take as long as a full day to complete, but I will be allowed breaks as needed. I may finish the evaluation on another day if needed to give my best performance. Feedback will be provided at the completion of testing, or arrangements will be made to provide feedback at a later date.

1) **Typical costs.** A typical evaluation is comprehensive and includes not only the time spent directly with the patient, but also time spent reviewing records, scoring the tests administered, interpreting the results, conferring with other healthcare professionals and writing the report. Depending on the complexity of the situation, this can add 4 – 8 hours to the direct contact time. If I am covered by an insurance company that Dr. Michael A. Fraga and/or Neuropsychological Associates is contracted with (e.g., Anthem/Blue Cross, Aetna, Medicare/Medicaid, Cigna), then he will accept that contracted rate plus my copay. Otherwise, the typical cost for a neuropsychological evaluation is (\$3000.00) three thousand dollars. Additional information on fees is available upon request.

2) **Payment:**

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- **Payment due before session.** My portion of payment is due at time of service, paid before the session, unless arrangements are made in advance. I understand that I will be asked to provide a credit card number at the time of booking (initial). We apologize for any inconvenience, however, no appointment will be scheduled without providing a valid credit card number.
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- **Assignment of benefits.** By signing below, I am authorizing the insurance company to pay benefits to Dr. Michael A. Fraga, Inc. / Neuropsychological Associates. When Dr. Michael A. Fraga, Inc. / Neuropsychological Associates bills the insurance company, payment for services is thereby directed to him; if the insurance company accidentally sends the check to me, it is my responsibility to turn the check over to Dr. Michael A. Fraga, Inc. / Neuropsychological Associates. Dr. Michael A. Fraga, Inc. / Neuropsychological Associates may need to communicate certain summary information to my insurance company in order to

obtain authorization and payment for this evaluation. Late payment is subject to 1.5% in charges each month. Neuropsychological Associates also reserves the right to use a collection agency if payment is not received in a timely manner.

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- **Self-Pay.** A reduced rate is offered for those people who would like to pay *in full* at time of service. In a self-pay arrangement, Dr. Michael A. Fraga, Inc. / Neuropsychological Associates will assist me in billing my insurance company, but will leave that ultimately between me and my insurance company.
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- **Cancellation Without Notice:** If I fail to show up for a scheduled Neuropsychological Assessment, or fail to provide 24 hours notice, I will be charged a non refundable fee of \$300.00 (initial). This fee must be paid prior to beginning the evaluation.

I am welcome and encouraged (but not required) to bring my husband/wife/spouse or significant other to the interview and feedback sessions.

I understand and agree with the above.

Signature of Patient

Date

Signature of Legal Guardian, if applicable

Date