Cognitive Health *Solutions* LLC

Main Office (Hanover):
100 West Eisenhower Drive, Suite A
Hanover, PA 17331
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York, PA 17402
Phone: (717) 747-3659
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Chambersburg Office:
550 Cleveland Avenue, Suite 101
Chambersburg, PA 17201
Phone: (717) 446-0232
Fax: (717) 632-9300

Financial Responsibility for Services Rendered with Cognitive Health Solutions, LLC

Name: Patient Name (if different):

Address	City	State	Zip Code
Cognitive Health *Solutions*, LLC	100 West Eisenhower Drive, Suite A	Hanover	PA	17331
Company	Billing Address	City	State	Zip Code

Please understand that full payment of your account is considered part of your treatment with Cognitive Health *Solutions,* LLC, and this document must be completed and signed to indicate an understanding of responsibility. Although we make every effort to obtain accurate information from the insurance carrier, insurance benefits are not a guarantee of payment, and **it is our policy that testing will not be completed without a credit card on file**. *Testing for educational or learning issues is not generally covered by insurance, and payment will be due on the last day of testing.* We will only charge this credit card for services not covered by insurance, and we will contact the cardholder before any charges are made.

Please note that until an account is Paid-In-Full a testing report will not be released.

Card on File

Type of Card: ☐ VISA ☐ DISCOVER ☐ MasterCard

Credit Card No:

Expiration Date: Month / Year **Security Number:** 3 Digits on Back of Card

Name on Card:

Address for Card (or write "Same As Above") City State Zip Code

With my signature below, I authorize *Cognitive Health Solutions, LLC* to charge my credit card for any services rendered. I agree to pay all deductibles, coinsurance, copayment and any service charges deemed as a "patient responsibility" as identified by the insurance company. I understand there is no guarantee of payment and that I am responsible for the full amount. In addition, there are some services that are not covered by insurance as "medically necessary," such as educational testing or evaluation for learning problems or remediation services (e.g., Cogmed), and I agree to pay for these services in full, if applicable.

Signature: _____ **Date:** _____

*Revised 07/2013