## Behaviorial Pediatric & Family Therapy Program

## Authorization for Assessment, School Based Services, and/or EEG Neurofeedback

I am requesting that the following service(s) be completed with: _____
(Patient Name)

_____ Psychological Assessment
_____ Educational Assessment
_____ Classroom Observation
_____ School Meeting
_____ EEG Neurofeedback
_____ Other Service _____

I understand that my provider has attempted to obtain any prior authorization that may be required by my insurance company for the type of services I am requesting. I further understand that my insurance company may NOT cover part or all of the charges associated with these types of services. Additionally, I understand that my insurance company may not authorize the number of hours required to complete the requested services. Even though the services may not be covered by my insurance company, or may be identified as "not medically necessary" by my insurance company, I am still requesting that these services be provided.

I will assume full responsibility for complete payment of all charges associated with these services. I understand that I will be charged the clinic's full rate for all hours or services not covered or authorized by my insurance company, and that I will not receive a discount or insurance write-off for these additional hours.

I have discussed the costs for evaluation or other services with my provider, agree to the above conditions, and understand payment is due at the time the service is provided unless other arrangements have been made with the business manager.

_____ _____
Parent / Guardian Signature Date

_____
Relationship to Patient