Neuropsychological Assessment/ Therapy Services Release & Payment Agreement

I give consent to receive a neuropsychological assessment or therapeutic services through Marvelous Minds, Inc (MM). I understand that payment is due at the time of service, including any co-pay, co-insurance, or deductible and will pay with the credit card below. If applicable, MM will bill my insurance company for services with the insurance information I have provided. Once the claim is processed, any adjustments will be made promptly. I understand that in the event that my insurance company unexpectedly denies an authorization or claim, I will be responsible for the full amount. I give my permission for MM to bill this credit card according to my insurance company's Explanation of Benefits.

Credit Card Type: VISA MASTERCARD DISCOVER

Card Number_____

Exp. Date_____ CVC_____

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

☐_____ Date_____
Patient or Guardian Signature