



Powers Ferry Psychological Associates, L.L.C.

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Linda Foltz, Ph.D.
David M. Schwartz, Ph.D.

Insurance Coverage Limitation on Professional Service

Patient Name: _____

Responsible Party: _____

Insurance Carrier: _____

Dr. David M. Schwartz has informed me that he requested hourly units of Psychological or Neuropsychological Testing (which includes the time to test, score and prepare the report) from my insurance carrier in planning to address the referral question(s) at hand. It is Dr. Schwartz' professional opinion that such an amount of professional testing service is necessary to attempt to properly address the referral question(s). I understand that the above named insurance carrier has preapproved only _____ hours of the total requested testing service. Dr. Schwartz has given me the opportunity to purchase the remaining hour units at the standard hourly rate (\$150.00) for this office unless otherwise agreed upon in advance. I have been offered the option of a payment plan versus lump sum payment due at the time of service. I also understand that the units Dr. Schwartz requested is an estimate and the actual time may be less or more than anticipated.

Please initial, in the space provided, either of the following two options.

_____ Yes, I **do** accept financial responsibility for the payment of the above remaining hour testing units. I understand that these additional testing services, beyond what has been approved by the above noted insurance carrier, will be provided on a self-pay/private pay basis.

_____ No, I **do not** accept financial responsibility for the payment of the above remaining hour testing units. I understand and accept that the additional recommended testing services, beyond what has been approved by the above noted insurance carrier, will not be provided at this time. I have been informed that the restricted professional services resulting from my decision not to accept financial responsibility for the additional recommended service may very well restrict the accuracy of any diagnosis to be offered as well as limit the accuracy of any treatment recommendations. I hereby release and absolve Dr. Schwartz from any and all professional responsibility and legal liability for any inaccuracy and/or limitation in professional care which may result from my instruction to Dr. Schwartz to deliver only those services which I contract with him through my insurance carrier.

Please initial, in the space provided, that you understand your financial responsibility.

_____ I understand that I am responsible for any balance not covered by my insurance. Pre-authorizations do not guarantee payment for services rendered. I am responsible for costs that I incur during the evaluation process.

I understand that I may appeal my insurance carrier's decision regarding the above decision to approve fewer testing hour units than requested and that such an appeal may delay Dr. Schwartz' ability to deliver professional services within my insurance carrier's contractual limits and provisions.

Date: _____ **Responsible Party:** _____

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