Touchstone Neurodevelopmental Center LLC
304 Cambridge Road, Suite 320 Woburn, MA 01801
Tel 782-497-8164 | Fax 855-421-8645

touchstone
NEURODEVELOPMENTAL CENTER

RELEASE OF BILLING INFORMATION, ASSIGNMENT OF BENEFITS, AND FINANCIAL RESPONSIBILITY

Release Of Billing Information: I authorize Touchstone Neurodevelopmental Center LLC (Touchstone) to release by electronic means or otherwise my/my child's protected health and/or billing information for treatment and payment of treatment. I understand that Touchstone will share this protected health information according to federal and state law for treatment and payment, as well as in accordance with its Notice of Privacy Practices.

I authorize Touchstone to release my medical or billing information, including copies of my/my child's medical records, to the following:

A. Any person or entity responsible for payment for the medical services rendered to me/my child at Touchstone, including third party payors, self-insurers, worker's compensation carriers and government agencies or any person or entity acting as the agent or contractor of such party responsible for payment, in connection with obtaining payment for the medical services rendered to me/my child at Touchstone by any person providing services at Touchstone
B. Federal, State or other governmental or quasi-governmental agencies or such other parties required by law for reporting purposes or for purposes of determining eligibility in government sponsored benefit programs
C. Any person or entity participating in quality review, utilization review or similar examination of the care rendered by Touchstone
D. Any health professionals involved in my/my child's care for the purpose of facilitating continuity of care

I acknowledge that the above authorization has no expiration date and is valid to authorize the release of medical records and billing information at any time a valid request is received. This includes information relative to alcohol abuse, drug abuse, psychological or psychiatric conditions.

Assignment Of Insurance Benefits: I authorize my medical insurance benefits to be assigned (paid) directly to Touchstone Neurodevelopmental Center LLC. I understand that I am financially responsible for all charges whether or not they are reimbursed by my insurance company, including non-covered services, any deductibles, coinsurance or amounts in excess of insurance benefits. If coverage is denied, I give my express consent to appeal to the insurance on my behalf.

Financial Responsibility: In consideration of services rendered or to be rendered to the patient designated herein at my request for this occasion of service, I guarantee and agree to pay charges for those services rendered including any amount not paid by my insurance plan, Medicare, health service plan or health maintenance organization. Members of health maintenance organizations (and preferred provider organizations) are generally required to comply with certain policies and procedures requiring use of participating providers and compliance with plan requirements for primary referral, emergency admission, pre-certification and utilization review. These are conditions to payment of benefits by the health maintenance organizations (and preferred provider organizations). Touchstone Neurodevelopmental Center may not participate with your health care coverage plan and our charges may not be covered.

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A special note about neuropsychological testing:

Dr. Mauras currently accepts BCBS for neuropsychological testing. However, many BCBS plans require prior authorization (also known as prior approval or verification of services) from BCBS before the appointment is scheduled. Yet, this approval before the visit does not guarantee payment! *Your insurance company makes a final determination of payment only after the testing is complete and we submit a claim.* **All monies owed by you, i.e., co-payment, co-insurance, deductible, and non-covered services are due promptly. We will ask for a credit card to keep on file.**

By signing the financial responsibility statement, the patient/guarantor(s) acknowledge and agree that they are responsible for payment of billed charges rendered in any case in which payment may be denied by the health maintenance organization (or preferred provider organization) because of a failure to comply with such coverage requirements or any other reason.

A copy of this form shall have the same force and effect as the original.

I acknowledge that I have read and fully understand the contents of this release. The undersigned is the patient, the patient's legal representative, or is authorized by the patient to execute this form and accepts its terms.