Arrowhead Psychological & Behavioral Sciences, LLC

1501 14th Street West, Suite 230 Billings, MT 59102 406-294-9510

Neuropsychological Evaluation Fee/Insurance Agreement

Client Name: ______________________________________ M _____ F_____

Date of Birth: ________________________Soc. Sec. # ____________________________

Address: _______________________________ City: ___________ St: ___ Zip code: __________

Phone: Work ___________________________ Home ______________________________

Parent/Guardian Name: ____

Address (if different than above) ____

City: __________________________ State: ____________ Zip: ______________________

Phone: Work: _______________ Home: _______________________________________

Emergency Name and Number: ____

If you have insurance, please fill out the following:

Name of Insurance Company: ____

Insurance Address: ____

Insurance Phone Number: ____

Group or Policy Number: ____

Insured's ID Number: ____

Insured's Name: ____

Address: ______________________________ City: _________________ St: ____ Zip code: _________

Phone Number: Work: _________________________ Home: ____________________________

Insured's DOB: ______________________________ SS#: _______________________________

Are you a recipient of Medicaid or Medicare services?

Medicaid Number _______________________________________ DOB: _____________________

Medicare Company and Number: ____

The Fee for Service is $250.00 per hour for a neuropsychological evaluation:

Do you have any questions about fees or funding? Yes _______ No ________

- Appointments must be canceled 24 hours in advance to guarantee there will be no charge.
- Failure to cancel or show for appointments will result in a $250.00 charge.
- In the event that your account goes to collections, there will be a 30% collection fee added to your balance.

Please sign and date: ____

I herby authorize my insurance company to pay directly to:

Brenda K. Roche, Ph.D., LP – Arrowhead Psychological & Behavioral Sciences, LLC

Signed: ___________________________ Date: ____