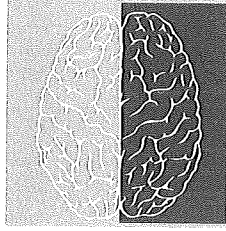


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NEUROPSYCHOLOGY SERVICE, P.A.

INSURANCE RELEASE FORM

I hereby authorize NEUROPSYCHOLOGY SERVICE, P.A. to bill my insurance carrier(s) for services provided to me, and to provide the information needed to process this claim.

I authorize payment directly to NEUROPSYCHOLOGY SERVICE, P.A. for the services provided. I assume responsibility for any balance not paid by my insurance company and have provided payment information for that purpose.

Printed Name

Signature

Date

Insurance Carrier