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1.888.539.4267
706.736.5864

A **biomarker** that **integrates** with your **ADHD assessment**

NEBA Health Benefits Support **FAX TO: (706)650-2160**
Patient Authorization

Patient Name:	Insurance Carrier:
Patient Date of Birth:	Insurance Phone:
Parent/Guardian:	Insured's ID #:
Phone #:	Insured's Group #:
Email Address:	Subscriber SSN#:
Clinician:	Subscriber DOB:
	Please include a copy (front and back) of your insurance card with this form.

I authorize my clinician and other healthcare professionals ("Clinicians") and my health plan or insurance company ("Insurer") to give NEBA Health information about my Health Care Information. This Information can include spoken or written information about my or my child's (collectively, "my") health and payment benefits, as well as copies of records from my Clinician or Insurers about my health or healthcare. I understand that I may revoke this Authorization by sending a written notice to NEBA Health. Revocation of this Authorization will be valid upon receipt by NEBA Health, except to the extent that NEBA Health has already taken action relying on this Authorization. I also understand that my revoking this Authorization will not affect my health care treatment or enrollment under a health plan. I also understand the information disclosed because of this Authorization may be re-disclosed by the recipient and may not be protected by the federal or state privacy regulations. NEBA Health may be required by contract to protect the confidentiality of this information but otherwise does not assume any responsibility for the information submitted. NEBA Health is providing its services "AS IS" without representations or warranties of any kind, express or implied, and cannot and does not accept any liability including for any inability to obtain coverage or reimbursement for me. In no event shall NEBA Health be liable for any direct, indirect, consequential, incidental, special or exemplary damages of any kind or nature arising out of the services. I hereby authorize NEBA Health to use the information described above for purposes of assisting to gain access and reimbursement for NEBA Health from my group health plan/Insurer and to otherwise support my care. All reimbursement information provided by NEBA Health is for general guidance only. It does not represent a statement, promise or guarantee by NEBA Health concerning levels of re-imbursement, payment, or charge, if any. Coverage and payment for NEBA is based on various factors, including but not limited to; medical necessity, the patient's specific benefits plan, and individual insurance company's policies and guidelines. It is the responsibility of the clinician and patient to be knowledgeable of the applicable guidelines.

_____

Signature: DATE

If signed by a caregiver, describe the authority to act on behalf of patient:

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