PSYCHOLOGICAL AND SCHOOL SERVICES OF EASTERN CAROLINA, PLLC
KELLY C. MOYNAHAN, PhD, LPA, HSP-LPA
1025 Director Court, Suite A/1, Greenville, NC 27858

Dear Client,

Though it is not uncommon for third party payors to deny direct classroom/social observations, extensive testing, and or testing for learning disabilities, the information gleamed from this testing is well worth the expense. Your insurance company generally allows six hours of evaluation/scoring/interpretation/writing for each diagnosis present. However, if diagnosis is ruled out, your insurance company may choose not to cover the cost. The cost of the entire evaluation will vary greatly depending on presenting concerns. The out of pocket cost is $150.00 per hour. Though a flat rate may be acceptable when testing for a learning disability (intelligence and achievement assessment). Flat rate is $760.00 with an additional cost for further assessments conducted (or example, ADHD, Autism, emotional-based disorders, neuro-psych, etc.). If you determine that it is a valuable service and wish to sign a waiver insurance reimbursement if your health provider declines payment, we can begin the evaluation. My office will bill you directly for this service. Please contact my office administrator, Melinda Bustamante, at (252) 256-3343 if you have any addition questions or concerns. Thank you for your interest in psychoeducational/emotional/neuropsychological evaluation(s).

Thank you, Kelly Moynahan, PhD, LPA, HSP-LPA, dba Psychological and School Services of Eastern Carolina, PLLC

WAIVER:

(Patient's Name or Parent/Guardian Name) I:_____, relieve Kelly Moynahan, PhD, LPA, HSP-LPA, dba Psychological and School Services of Eastern Carolina, PLLC, of any contractual arrangement with (Health Insurance Provider Name) _____- - - _____ regarding extensive evaluation scheduled to rule-out a diagnosis. It is my opinion that the evaluation is worthwhile, and I am willing to cover the cost. I would like testing conducted for my child/myself. Please schedule the evaluation and bill me directly. I am aware that third party payors do not cover additional expense, may not cover the cost of some diagnoses, and or may not cover the cost if no diagnosis is found. I am aware that I am responsible for the entire cost of this portion of the evaluation.

PATIENT'S SIGNATURE _____

PARENT/GUARDIAN OF PATIENT _____- -

- - ____

DATE _____

WITNESS ____