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Financial Responsibility Form

Payment Information for: _____

Financially responsible party: Self ☐ Parent ☐ Other ☐

Please provide the following information about the Financially Responsible Person(s)
(ONLY IF IT IS NOT YOU)

Name: _____ Date of Birth: _____

Relationship to client _____Home phone: _____ Cell/Work phone: _____

Employer: _____Occupation: _____

Billing address _____
street city state zip

Payment/Insurance Agreement & Authorization to Send Reimbursement Information

I accept responsibility for payment of charges for services rendered to the above named person. I understand that full payment is expected at the time services are rendered unless the therapist agrees otherwise. I also understand that any court order I have is an agreement between me and the courts NOT the therapist and I am still responsible for payment of all charges. I understand and agree that I may be charged for and required to pay for missed appointments not cancelled at least 24 hours in advance. I further understand and agree that a collection agency and/or the courts may be used in the event of delinquent payment, and I realize that such action could require that the therapist release to the collection agency, attorneys, and/or the courts, information which identifies the parties involved, gives the client's diagnoses, and describes the dates and nature of the treatment. I also understand that, in the event that my health insurance changes or its coverage and/or benefits are altered by me in any way, I shall be responsible for the unpaid amount should my insurance claims be denied. Pursuant to said insurance, I understand that I am responsible for informing therapist of any coverage and/or benefit changes as quickly as possible and that my failure to do so holds me liable and responsible for direct payment to therapist of any and all denied claim amount(s).

This consent shall remain in effect until all outstanding balances have been paid in full.

_____ _____
Signature of person who will be financially responsible for fee payment Date

Note: **If another party is paying for your treatment, they will need to sign this page even if it is not you.**