FINANCIAL RESPONSIBILITY

DATE: **ACCOUNT NO.:** **DX:**		
FINANCIAL RESPONSIBILITY		
Client Last Name:	Client First Name:	
Birthdate: / /	Age:	Gender:
Street Address:	City:	State: Zip Code:
Client Home Phone:	Client Cell phone:	Best number to leave messages:
_____Initial ***I agree to be financially responsible for all costs resulting from the treatment and/or evaluation of the above named client.***		
My relationship to the client is: □ Parent □ Spouse □ Partner □ Guardian Ad Litem □ Family Member □ Other		
FINANCIAL PAYOR'S INFORMATION		
Street Address:	City:	State: Zip Code:
Home Phone:	Cell Phone:	Best number to leave messages:
Date of Birth:		
Each session must be paid in full at the time of service. I understand I am accepting responsibility for the cost of treatment and I plan to submit payment by: □ Cash or check sent with the patient □ Completion of the credit card authorization form		
Signature:		Date: