

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:
<p>Initial <i>I agree to be financially responsible for all costs resulting from the treatment and/or evaluation of the above named client.</i></p>			
<p>My relationship to the client is: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Partner <input type="checkbox"/> Guardian Ad Litem <input type="checkbox"/> Family Member <input type="checkbox"/> Other</p>			
FINANCIAL PAYOR'S INFORMATION			
Street Address:		City:	State: Zip Code:
Home Phone:		Cell Phone:	Best number to leave messages:
Date of Birth:			
<p>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:</p>			
<p><input type="checkbox"/> Cash or check sent with the patient <input type="checkbox"/> Completion of the credit card authorization form</p>			