

## FINANCIAL RESPONSIBILITY

DATE:		ACCOUNT NO.:		DX:	
<b>FINANCIAL RESPONSIBILITY</b>					
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><b>I agree to be financially responsible for all costs resulting from the treatment and/or evaluation of the above named client.</b></i>					
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					
<b>FINANCIAL PAYOR'S INFORMATION</b>					
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:					
<input type="checkbox"/> Cash or check sent with the patient <input type="checkbox"/> Completion of the credit card authorization form					