**FINANCIAL RESPONSIBILITY**

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| **Date: Account No.: Dx:** | | | | |
| **Financial Responsibility** | | | | |
| Patient Last Name: | | Patient First Name: | | |
| Birthdate: / / | | Age: | | Gender: |
| Street Address: | | City: | | State: Zip Code: |
| Patient Home Phone: | | Patient 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 patient.*** | | | | |
| My relationship to the patient 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  □ Pay a retainer discussed in advance by Dr. Pender to be held by Next Step Psychology | | | | |
| **Insurance Information** | | | | |
| Name of Insurance: Plan Number: | | | | |
| Name of Insured: | Birth Date: | | | SSN: |
| Name of Employer: | | | | |
| □ I want Next Step Psychology to file my insurance  □ I am not interested in filing insurance at this time. | | | | |
| \_\_\_\_\_ Initial ***I understand that filing insurance is a courtesy provided by Next Step Psychology and does not guarantee payment. I may read more about insurance policies in the Business Policy and Patient Agreement paperwork.*** | | | | |
| Signature: Date: | | | | |