**FINANCIAL RESPONSIBILITY**

|  |
| --- |
| **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:  |