1745 S. Alma School Rd. Suite 230
Mesa, AZ 85210
Phone: (480) 668-8301
Fax: (480) 558-3020

If services are being paid by an outside source (other than the patient or custodial guardians) then this form must be completed PRIOR to the initial intake session.

Third-Party Payment Agreement for Psychological Services

(i.e. clergy, family, friends, businesses etc.)

Patient Name: Date of Birth:

Parent/Guardian Name: Contact Phone Number:

Home Address:

City, State Zip

Name of Third Party Payer: Payer Contact Phone Number:

Organization: Payer Email Address:

Billing Address:

City, State Zip

Therapist Name:		Hourly Rate:	$
Group Program:		Group Cost:	$

The patient listed above will be receiving financial assistance with all or part of their therapy at Family Strategies. I have indicated below the agreement we have reached and signed. Payment will be mailed in upon receiving monthly billing statements from Family Strategies.

- ☐ I agree to pay the full cost of therapy for the above patient
- ☐ I agree to pay the balance of therapy after a $_________ payment is made by the above patient for every therapy session.
- ☐ I agree to pay for group therapy only
- ☐ I agree to pay for individual therapy only
- ☐ I agree to pay for couples counseling only
- ☐ Other: (Please Specify)

____

____

____

Signature of responsible party: Date:

Signature of patient or guardian: Date:

For office use only:	Consent to exchange information on file:	_______YES ________NO _________Limited