FAMILY STRATEGIES
COUNSELING CENTER

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Third-Party Payer Agreement for Psychological Services

This is **NOT** a contractual agreement. This is an understanding between patient, third-party and Family Strategies.

PATIENT SECTION

Patient Name: Date of Birth:

Parent/Guardian Name:

Contact Email: Contact Phone number:

My signature allows the payer listed on this form and Family Strategies to communicate about my goals, progress and needs without me being present. This is not required by Family strategies but may be a condition set by the third-party payer below for assistance.

X_____

Signature declined. Only correspondence between payer and Family Strategies will be the information included on billing statements.

- **Any balance over 120 days past due becomes the responsibility of the patient**. *Patients are encouraged to keep track of their account via the Patient Portal.*
- **The PATIENT is responsible for any No-Show or Late Cancellation fees**, not the third-party payer.
- A Credit Card is **required** to be on file with Family Strategies from the patient. Your card will be charged immediately for any no-show or late cancellation fees.
- It is the **patients responsibility** to ensure that they update Family Strategies with any changes to the payer's information, including a change of status (common for clergy).

PAYER SECTION

Name of Third-Party Payer: Relationship to Patient:

Organization:

Billing Address:

City, State, ZIP:

Payer Email Address: Payer Phone Number:

I agree to pay the **FULL COST** of **ANY therapy** for the above patient.

I agree to pay for ONLY the following therapies: Individual Family Couples Group _ Other:_____

I agree to pay the balance of therapy after a $_____ payment is made by the patient for every session.

I agree to pay for _____ total sessions. *(A new form will need to be filled out for ANY extension to this agreement)*

- The patient listed above will be receiving financial assistance from the person/organization listed in this document. Both patient and payer are in agreement and both have signed this form below.
- Payer agrees to send in payment immediately upon receiving monthly billing statements from Family Strategies.

We apologize for any inconvenience but all statements MUST BE SENT DIRECTLY TO THE THIRD-PARTY PAYER

Signature of Patient: Date:

Signature of Payer: Date:

VALID FOR ONE YEAR FROM DATE OF SIGNATURE ONLY