FINANCIAL AGREEMENT

HELP US TO HELP YOU

Please understand that you are financially responsible for your treatment and that payment is expected when services are rendered.

How would you like to pay for services today and future visits?

Please indicate below:

_____ Cash

_____ Check (please make check out to **Counseling Network, Inc**.
(Please make our your check before your session.)

_____ (circle one) Visa MasterCard Discover American Express

Card #: _____ Exp. Date: _____

I authorize **Counseling Network, Inc** to use my credit card for payment of ongoing sessions, including no-shows and late cancellations, until discharge or my request to stop billing.

_____

Client Signature Date

You will be provided with an invoice to obtain reimbursement from your managed care company or to be used for tax deduction purposes upon request.

In the event that your past due account is sent for collection or to an attorney, you will be assessed a $40.00 collection fee for each and every time your account becomes past due and has to be billed.

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All uncollected accounts may be reported to a credit bureau or filed in small claims court.

I have read and agree to all above-mentioned items

_____

Printed name

_____

Client Signature Date

Counseling Network, Inc.
P.O. Box 144448
Coral Gables, Florida 33114
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