FINANCIAL RESPONSIBILITY
Patient/Guarantor Information

Patient information

Name:_____

Address:_____City_____State_____Zip_____

Phone#_____Work#_____Cell#_____

Date of Birth:_____ Sex: ___M ___ F Email:_____

Guarantor Information (If different from patient above)

Name:_____Social Security#_____

Address:_____City_____State_____Zip_____

Phone#_____Work#_____Cell#_____

Relationship to Patient: ___Spouse ___Child ___Other_____

Date of Birth:_____ Sex: ___M ___ F Email:_____

Employer:_____

Please initial that you understand the following:

_____I understand that fees for services are rendered based upon time involved and that time spent by me or on my behalf (per my request) is billed based upon my established hourly fee.

_____I understand that if I cancel a scheduled appointment without 24 hours notice or do not show up for an appointment, I am subject to a full charge for the session.

_____I understand that for all returned checks I will be charged a fee of $25.00

I hereby authorize Freedom Counseling Services, LLC. to charge my credit/debit card for services rendered, missed appointments, and returned check fees.

Name on Credit/Debit Card:_____

Card#_____-_____-_____-_____ Expiration Date:_____ /_____ /_____

Check One: ___Visa ___MasterCard ___Discover ___American Express

Card Holder Signature:_____ Security Code on back of card:_____

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____Printed name of Patient/Parent/Legal Guardian/Personal Representative

_____ _____

Signature of Patient/Parent/Legal Guardian/Personal Representative **Date**