AFI SELF-PAY FORM

(To be completed by a responsible party 18 years or older)

FULL PAYMENT IS DUE AT THE TIME OF SESSION.

Client's Name: _____

Parent/Guardian Name: _____
(if applicable)

Therapist's Name: _____

Agreed Upon Rate: _____

APPOINTMENTS CANCELLED OR MISSED WITH LESS THAN 24 HOURS' NOTICE WILL BE CHARGED TO YOU AT YOUR SELF-PAY RATE.

By being a self-pay client, you agree not to have your insurance billed each session and/or acknowledge that you do not have an insurance plan to be billed. By signing this form, you agree to pay the self-pay rate agreed upon between you and your therapist each session.

We accept cash, check, MasterCard, Visa, and Discover. A $25 fee is charged on all returned checks.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES.

Print Name of Person Responsible for Account: _____

X_____

Signature of Person Responsible for Account Date