Silber Psychological Services, P.A.
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STATEMENT OF FINANCIAL RESPONSIBILITY

Your Name _____
First *MI* *Last*

Your Address: _____
Street *City* *State* *Zip*

Home Phone Number: _____ Cell Phone Number: _____

Your Relationship to the Patient: ☐ Parent ☐ Spouse ☐ Guardian Ad Litem
☐ Other: _____

Patient Name: _____
First *MI* *Last*

Patient Address: _____
Street *City* *State* *Zip*

I agree to be financially responsible for all costs incurred for the evaluation / treatment of the above named patient.

Seeing that each session is paid in full at the time of services is my responsibility, and for those visits where I will not be present, I will:

- ☐ Send payment with the patient
- ☐ Complete a Credit Card Authorization Form to be kept on file
- ☐ Pay a Retainer amount that has been mutually agreed to and replenish as needed

Signature: _____ Date: _____

Office Manager's or Therapist's Signature: _____ Date: _____