Family Restoration
COUNSELING SERVICES

Third Party Payer Authorization Form

For Completion by Third Party Payer:

Client Name _____ DOB _____ Payer Relationship to Client _____

Payer Name _____ Phone _____ Email _____

Billing Address (Street, City, State, Zip) _____

Payment Information:

Name on Card _____

Card Number _____ Exp. (MM/YY) _____ CCV _____

Agreement:

By initialing each line, you understand and agree to the following:

____ I voluntarily agree to assume financial responsibility for the client(s) listed below and agree to pay the therapist's normal rate as well as any additional fees incurred by the client as explained in our Informed Consent (e.g. late cancellation fees, court fees, etc.).

____ I am not able access to confidential information regarding the client unless the client provides a signed Release of Information form (ROI).

____ A financial statement suitable for possible insurance reimbursement will be available upon my request and the client's written agreement. I understand that not all conditions and services may be reimbursed by my insurance.

____ I will notify FRCS if I need to make a change to payment information, or if I am no longer able/willing to pay for the client's services.

Payer Signature _____ Date _____