1745 S. Alma School Rd. Suite 230
Mesa, AZ 85210
Phone: (480) 668-8301
Fax: (480) 558-3020

FAMILY STRATEGIES
COUNSELING CENTER

Third-Party Payment Agreement for Psychological Services

(i.e. clergy, family, friends, businesses etc.) *(Revised 2/19/20)*

To be filled out by the patient

Patient Name: Date of Birth:

Parent/Guardian Name: Contact Phone Number:

Your signature below allows us to speak to your third-party payer about your financials.

X _____ Date: _____

To be filled out by the payer

Name of Third-Party Payer: Payer Contact Phone Number:

Organization:

Billing Address:

City, State Zip

Email Address:

Do you want e-statements*? ☐ YES ☐ NO **e-statements are sent directly to your email.*

The patient listed above will be receiving financial assistance with all or part of their therapy at Family Strategies. I have indicated below the agreement we have reached and signed. Payment will be mailed in upon receiving monthly billing statements from Family Strategies.

☐ I agree to pay the full cost of therapy for the above patient

☐ I agree to pay the balance of therapy after a $_____ payment is made by the above patient for every therapy session.

☐ I agree to pay for GROUP / INDIVIDUAL / COUPLES therapy only (please circle those that apply)

☐ Other: (Please Specify) _____

Signature of Third Party: Date:

Signature of patient or guardian: Date:

IMPORTANT:

Regardless of the payer, it is the client's responsibility to know the status of their account. **Any unpaid balances after 120 days will be the responsibility of the client**.