

**FINANCIAL INFORMATION**

Person responsible for payment: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**PERMISSION TO TREAT/FINANCIAL AGREEMENT**

I hereby give my consent for Cureton Counseling & Consulting, LLC to evaluate, counsel, and treat me and/or my family members. I agree to pay Cureton Counseling & Consulting, LLC in full for services rendered, for charges that are assigned for appointments not kept or late cancellations, and for service fees for past due accounts. I agree to also pay for any medical records copying fees if I wish my records to ever be released to me or another party. In addition, I agree to pay for any charges incurred in collection and said debt, including collection agency fees, attorney fees, and court fees. I understand that I am responsible for payment at the time services are rendered. Other payment arrangements are to be discussed prior to services being provided. I understand that I am responsible for insurance co-payments and deductibles, as well as any unpaid insurance balances.

**CHARGE FOR DIAGNOSTIC EVALUATION = \$175  
EACH SUBSEQUENT 55-60 MINUTE SESSION (BILLING CODE 90837) = \$175**

Signature of Client/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CLIENT COMMITMENT**

**I/We acknowledge that I/We have received, reviewed and understood the information presented on this page and general information page provided at the beginning of counseling. I/We agree to abide by the terms disclosed these documents.**

Signature of Client/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_