NEXT STEP PSYCHOLOGY PLLC

Dr. Carolyn Pender Roche, Ph.D, NCSP
carolyn@nextsteppsychology.com
Phone: (919) 228-8845
Fax: (919) 251-9660

FINANCIAL RESPONSIBILITY

DATE:	ACCOUNT NO.:	DX:

FINANCIAL RESPONSIBILITY

Patient Last Name:	Patient First Name:		
Birthdate: / /	Age:	Gender:	
Street Address:	City:	State:	Zip Code:
Patient Home Phone:	Patient Cell phone:	Best number to leave messages:	

_____Initial ***I agree to be financially responsible for all costs resulting from the treatment and/or evaluation of the above named patient.***

My relationship to the patient is:
□ Parent □ Spouse □ Partner □ Guardian Ad Litem □ Family Member □ Other

FINANCIAL PAYOR'S INFORMATION

Street Address:	City:	State: Zip Code:
Home Phone:	Cell Phone:	Best number to leave messages:
Date of Birth:		

Each session must be paid in full at the time of service. I understand I am accepting responsibility for the cost of treatment and I plan to submit payment by:

□ Cash or check sent with the patient
□ Completion of the credit card authorization form
□ Pay a retainer discussed in advance by Dr. Pender to be held by Next Step Psychology

_____ Initial ***I understand that filing insurance is a courtesy provided by Next Step Psychology and does not guarantee payment. I may read more about insurance policies in the Business Policy and Patient Agreement paperwork.***

Signature: Date: