

## PAYER AGREEMENT

Name of Organization: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

<b>Name of Individual:</b>
<b>Address:</b>
<b>City, State, Zip Code:</b>
<b>Phone Number:</b>
<b>Email Address:</b>
<b>Is individual a Minor?</b>
<b>Name of Parent/Guardian:</b>

Please indicate below the amount of financial assistance to be applied to individual's account:

- Pay the counselor's full billable rate for \_\_\_ sessions.
- Pay a percentage of the counselor's billable rate for a limited number of sessions.  
Clients will pay the balance.

Indicate the percentage amount (10%, 20%, etc.) to be paid by the 3<sup>rd</sup> Party \_\_\_\_\_  
Indicate the number of sessions \_\_\_\_\_

Payers are responsible for any missed appointment fees incurred.

Approved by:

\_\_\_\_\_

Print Name and Title

Signature

Date