



BILLING AND PAYMENT FOR SERVICES (Private Pay Clients)

Client Name: _____ D.O.B.: _____

I, _____, _____,
(print full name) (Relationship to the client)

agree to pay for services rendered as indicated by Fee Schedule established by Caramenico Counseling Group LLC. Fee for services are required at the time service is rendered. Currently, payment is accepted in the form of cash and check (made payable to Caramenico Counseling Group) I understand, upon my request, a monthly receipt will be provided to me of all payments made to date.

My signature also indicates that I understand that failure to pay fees for services rendered may result in suspension or termination of services at Caramenico Counseling Group LLC. I acknowledge that if my financial situation changes and I am unable to afford payment of services I may request consideration for fee assignment based on the group's sliding scale.

Client Name	Signature	Date
(All clients age 18 and older are required to sign this document)		

Parent/Guardian Name	Signature	Date
(Parent/Guardian must sign if child is under the age of 18)		

Independent Practitioner Signature and Credentials	Date
--	------

- Client (or Parent/Guardian) was provided a signed copy of this document.
- Client (or Parent/Guardian) declined a signed copy of this document.

Information Updated January 2018