Revised 01.29.2016

THIRD PARTY PAYER AGREEMENT

I accept full financial responsibility for the treatment of ____________________ and agree to the provisions of the Office Procedures & Financial Agreement.

Please indicate preferred method	Payment Options
	Credit card payment: You may provide the client with a credit card to present at the time of service or we can manually enter your credit card information (VISA/MC only) Card Number: _________________________________ Exp Date: _________CVC Code: ________ Zipcode:_________
	Payment at the time of service: You may provide the client with cash or check to remit when he/she comes in for an appointment. If, for whatever reason, the client runs a balance, you will need to provide a credit card number we can maintain on file.

You may elect to have a statement sent to you at the beginning of each month. The statement will reflect all payments you made for the previous month. If you would like a statement sent to you, please indicate your preferred method and include necessary information:

Email	Fax	Mail

____ ____________________
Signature of Third Party Payer Date

____
Print Name

Below to be filled out by client

I, ______________________ authorize the above to accept full financial responsibility for any services rendered at Chrysalis. I understand that by authorizing a Third Party Payer, that individual may obtain financial or billing information about my services at Chrysalis such as date of service, type of service, fee for service, and service provider. No clinical information will be given without a separate Release of Information.

___________________________________ _________________ ___________
Signature of Client Date Date of Birth

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