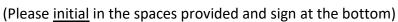
PROFESSIONAL SERVICES AGREEMENT





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Name of Responsible Party	Signature	Date
By signing below, I acknowledge the inherent conditions implied or state		ponsibilities noted above and agree to the
privacy practices. A copy of this noti time. Any changes will be effective f the revised notice at any time.	ce had been made available. We or all protected health information	alth information, and must inform you of our reserve the right to change this notice at any on that we maintain. You may receive a copy of
with a DOB:/	hereby give my consent for the	treatment of the child,,
Consent for Treatment Most people benefit by partici your family members will be helped	. •	however, there is no guarantee that you or
insurer. I authorize payment of insu settle whatever balance is generate	rance benefits to Creekside Coun d when payment is not received a	ssary to process fee for service claims to my seling. I accept the financial responsibility to after 60 days from the billing date. I sent to a third party for collection purposes.
charge of \$5.00 per month will be ch submittal to a collection agency or c	narged. Any account that has had court action. If your account is ser of service. I understand that failu	nsurance payment has been received a service I no payment activity for 90 days will qualify for nt to collection, a 12% interest rate will be ure to pay my bill will result in information
Additional fees may be billed freports or letters and other professi	•	more than 10 minutes in length, written
\$25 for counseling sessions and can reminder calls or texts, but it is not a	not be billed to insurance. Creeks guaranteed. Patients may not dis ations or no shows is established,	in advance will result in a charge. This fee is side Counseling will try to provide courtesy pute a no show fee based upon not receiving a patients may be referred to another office or ervices.
any services provided at Creekside C be sorted out by the parents and are	Counseling at the time of service. e not the responsibility of Creeks	d I agree that it is my responsibility to pay for Issues due to child custody agreements must ide Counseling. In signing for services for a to approve of the evaluation, treatment and
I agree to make payment at the I am a cash paying patient or meeting the control of the co		ny known co-pay, coinsurance, or the full fee (if

Patient Name:_____