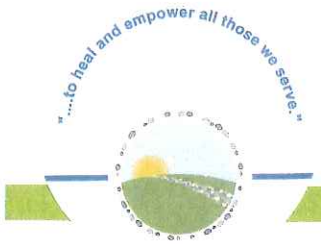

Child and Family Psychiatric Center

PATIENT PAYMENT AGREEMENT

It is our preferred office policy that payment is due at the time of service. However, we understand that occasionally patients may need to make a temporary payment agreement while receiving necessary treatment. Your mental health is our first concern and we are willing to extend the following payment agreement:

I agree to pay for services rendered by _____ , as indicated below.

My current patient account balance is $_____ as of (date) _____.

Are claims still pending with insurance? (Circle) Yes No

I understand that if claims are still pending with insurance at this time that I may owe an amount in addition to the amount listed above and I acknowledge that this agreement is to pay the amount listed above only, any additional balances owing would require an additional payment plan.

Patient's (or Authorized) Initials: _____

Date to be paid in full _____ OR ___ Payment schedule as follows:

Date_____ Amount to be paid_____

Date_____ Amount to be paid_____

Date_____ Amount to be paid_____

This agreement does not include co-pays on future dates of service. You are responsible to pay all co-pays at time of service AND adhere to this monthly payment plan.

Patient's (or Authorized) Initials: _____

It is understood that if the patient misses payments, without prior notification and agreement, this practice reserves the right to transfer collections to a collection agency.

Patients Printed Name: _____ D.O.B. _____

Patient/Responsible Party Printed Name: _____

Patient/Responsible Party Signature: _____

Staff Initials: _____ Date: _____

Office Use: _____ Note in Computer _____ Copy in File _____ Original in Office Manager Binder