



Center for Counseling & Recovery

1104 Vine Street, Suite A

Paso Robles, CA 93446

Phone (805) 227-4500 Fax (805) 227-4544

FINANCIAL AGREEMENT

For Professional services rendered or to be rendered to _____

I, _____ agree to pay:

Print Name

1. Fee for services (per visit): _____

2. Amount covered by insurance: _____

3. Amount paid by patient: _____

4. Deductible amount: _____

5. Deductible met? Yes No

A. Payment Agreement _____

NOTE: Insurance company **WILL NOT** pay for a missed or late cancel session. Client is responsible for **FULL** payment of these sessions.

Insurance Company _____

Subscriber's Name (if different from patient) _____

Subscriber's Social Security Number _____

Signature of patient or parent if patient is a minor:

Patient's Signature

Valid Date From

Therapist's Signature

Valid Date To

Center for Counseling and Recovery – Release of Information Consent

I, _____, authorize _____ to:

____(send) ____ (receive) the following ____ (to) _____ (from)

the following agencies or people:

Name _____
Address _____ City _____ State _____ Zip _____

Name _____
Address _____ City _____ State _____ Zip _____

Name _____
Address _____ City _____ State _____ Zip _____

- | | |
|---|--|
| <input type="checkbox"/> Academic testing results | <input type="checkbox"/> Psychological testing results |
| <input type="checkbox"/> Behavior programs | <input type="checkbox"/> Service plans |
| <input type="checkbox"/> Case notes | <input type="checkbox"/> Summary reports |
| <input type="checkbox"/> Intelligence testing results | <input type="checkbox"/> Vocational testing results |
| <input type="checkbox"/> Medical reports | <input type="checkbox"/> Entire record |
| <input type="checkbox"/> Personality profiles | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Progress reports | _____ |
| <input type="checkbox"/> Psychological reports | _____ |

The above information will be used for the following purposes:

- Planning appropriate treatment or program
- Continuing appropriate treatment or program
- Determining eligibility for benefits or program
- Case review
- Updating files
- Other (specify)

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

Client's signature _____ Date ____/____/____

Parent/guardian signature _____ Date ____/____/____

Witness (if client is unable to sign) _____ Date ____/____/____

Person informing client of rights _____ Date ____/____/____

Mail to _____

Address _____ City _____ State _____ Zip _____