

**[ENTER PROGRAM NAME HERE]
CLIENT FEE AGREEMENT**

Please Note: Client fee agreements are to be updated every 90 days or when the financial status of the client changes (whichever comes first).

CLIENT NAME: _____ CLIENT ID# _____
S SOCIAL SECURITY # _____ DATE OF BIRTH: _____
CLIENT ADDRESS: _____ PHONE NUMBER: _____
EMPLOYER: _____ PHONE NUMBER: _____
EMPLOYER ADDRESS: _____
POSITION: **A** _____ LENGTH OF EMPLOYMENT: _____
TYPE OF SERVICE: _____ DATE OF ADMISSION _____

PAYMENT WILL BE MADE BY:

Client Amount to be Paid:(See Attachment A)

Insurance: **M** _____ Policy # _____
Probation: _____
Community Corrections: _____
D.S.S. (Designate MOST or PS) _____
Medicaid or Medicare: **P** _____
Subsidy (See Subsidy Form): _____

*I understand that fees are to be paid at the time that services are rendered. **A no show fee for \$_____ will be charged when an appointment is scheduled that I do not keep unless the program is notified 24 hours in advance of the cancellation/ reschedule. The program may refuse service to me if my account becomes 3 visits past due in payment.***

WAIVER/ADJUSTMENT REQUESTS (attach appropriate documentation) **L**

Yes No Initial _____

Client Signature _____ Date: _____

Staff Signature _____ Date: **E** _____

Director and/or Finance Manager: _____ Date: _____