

Silber Psychological Services, P.A.  
www.silberpsych.com

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**FINANCIAL RESPONSIBILITY**

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

I agree to be financially responsible for all costs incurred for the evaluation/treatment of the above named patient.

My relationship to the patient is:

Parent  Spouse  Guardian Ad Litem  Family Member  Other

Name: \_\_\_\_\_  
First MI Last

Address: \_\_\_\_\_  
Street City State Zip

DOB: \_\_\_\_\_ Home Phone No. \_\_\_\_\_ Work Phone No. \_\_\_\_\_ Cell No. \_\_\_\_\_

Seeing that each session is paid in full at the time of rendering of services is my responsibility. I may:

- \_\_\_\_\_ Send cash/check with patient.
- \_\_\_\_\_ Complete the credit card authorization form.
- \_\_\_\_\_ Pay a retainer agreed upon by Silber Psychological Services management.

**Insurance Information (if applicable):**

Name of Insurance: \_\_\_\_\_ Plan Number: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Birth date: \_\_\_\_\_ SSN: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

I understand that filing insurance is a courtesy and does not guarantee payment. I may read more about insurance policies in Silber Psychological Services Business Policy and Patient Agreement.