PAYMENT AGREEMENT

I, _____ (name of adult client or guardian of minor client) agree to pay PBJ Connections, Inc. at the current rate for services provided to me (or the client named above for whom I have legal responsibility). I understand that I am responsible for these charges and that **fees are due at the time service is provided**, unless I make arrangements in advance. If grant-funded, these policies only apply to late cancellation/missed appointment fees. I understand that by signing I am acknowledging that I have been given and understand the PBJ Connection, Inc. Policy Information, including that I may be charged a $50 late cancel/no show fee for sessions cancelled without 24 hours notice. I understand that I am responsible for the full rate contracted by my insurance company (if applicable) including copays, co-insurance, and deductibles.

_____

Client or Guardian Signature Date

CONSENT FOR TREATMENT

By signing, I give consent to receive ongoing outpatient treatment for myself, my child, or my family at PBJ Connections, Inc.

I am signing on behalf of:

- ❑ Myself
- ❑ My Child

_____ _____

Signature Date

_____

Child's Name (If applicable)

Privacy Notice and Policy Information

I have read, or have had read to me, and understand the Privacy Notice in its entirety (4 pages) and the Policy Information in its entirety (4 pages) and I have been offered a copy of both.

_____ _____

Signature Date