Bishop Pay Financial Agreement for Therapy

This form is for individuals seeking treatment using "Bishop Pay" as their only source of payment for therapy.

Date:_____

Name of Patient:_____ **DOB:**_____

Name of Bishop:_____

Bishop Phone #_____ **Bishop email:** _____

Bishop Address: _____ **City** _____ **Zipcode** _____

I, the Bishop of the above-named Patient, assume financial responsibility for the treatment offered at *Rogue Valley Trauma Recovery* for a specific number of therapy visits. If more visits are recommended by the therapist, another Financial Agreement will need to be filled out to approve payment. By my signature below, I authorize *Rogue Valley Trauma Recovery* personnel to communicate with me by mail, phone, answering machine message, and/or email regarding the subject matter of this Financial Agreement.

Fees:
Initial Assessment: $120
Therapy Session: $80

Number of therapy sessions approved by Bishop (including initial assessment)_____
In addition, Bishop recognizes that the Patient may incur, and Bishop will be responsible for, the payment of additional charges at the discretion of Ascendant. These charges are only applicable to visits approved under this agreement and may include, but are not limited to, charges for returned checks, charges for missed appointments without 24 hours advance notice, and any costs associated with collection of patient balances.

Bishop Signature:_____**Date:**_____

It is the sole responsibility of the patient to make sure these Financial Agreements are in order and approved before each therapy visit. If the patient has a therapy session without a financial agreement in place, the financial responsibility will fall to the patient.

Patient Signature:_____**Date:**_____

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