CHILD AND FAMILY COUNSELING CENTER
13649 OFFICE PLACE, SUITE 102
WOODBRIDGE, VA 22192

Signature on File-Lifetime Form And Payment Agreement

1. **I authorize the use of this form on all my insurance submissions.**

2. **I authorize the release of medical information about me to all my insurance company(s) when needed to determine benefits payable for related services.**

3. **I authorize CFCC to act as my agent in helping me obtain payment from my insurance company(s).**

4. **I understand that if my insurance company(s) have not made payment after a period of 90 days, I am responsible for my bill. I will promptly pay CFCC in full for services and continue litigation with my insurance company(s) to seek reimbursement for myself.**

5. **I authorize payment directly to CFCC.**

6. **I permit a copy of this authorization to be used in place of the original.**

7. **I agree to make payment in full for all services rendered within 90 days of date to treatment, (For those patients who file their own insurance and/or Cash patients.)**

8. **Patient/Guardian is responsible to notify the receptionist of any insurance changes failure to do so may result in non payment from your insurance company. This will make the patient/guardian responsible for payment.**

9. **Failure to show up for three office visits without notification 24 hours prior to appointment may result in being terminated for any future care.**

Patient Name____

Signature of Patient or Guardian of Minor____________________________

Date____________________