**LIVING WELL BEHAVIORAL HEALTH, INC.**

**FINANCIAL ACCEPTANCE FORM**

YOU ARE EXPECTED TO PAY YOUR CO-PAY, DEDUCTIBLE, CO-INSURANCE, AND ANY PAST DUE BALANCE ON YOUR ACCOUNT AT THE TIME OF SERVICES.

THANK YOU.

We will make your payment as easy and convenient as possible. You may pay by cash, check, credit card, or debit card. Please read the following and sign at the bottom to accept these terms.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to pay my co-pay, deductible, co-insurance,

(Client Name Printed)

and any past-due balance on my account at the time of service.

Client or Responsible Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_