-CONFIDENTIAL-

APPLICATION FOR ALTERNATIVE FINANCIAL AGREEMENTS FOR PROFESSIONAL SERVICES

This application has been prepared to provide the option of alternative financial arrangements for clients who desire professional services, but have financial constraints that would otherwise preclude their receiving them.

We DO NOT have the option of offering PAYMENT PLANS. We are happy to provide a fee reduction in cases in which the client qualifies.

Your financial information will be held in the strictest of confidence.

Thank you

Name: _____ Date of Birth: _____
Last First Middle

Address: _____

_____
City State ZIP

Social Security #: _____ Driver's License #/ State: _____

Telephone: (Home) _____ (work) _____

Occupation: _____

Employer: _____ Phone: _____

Address: _____

_____
City State ZIP

Current Monthly Income: _____ Bonuses: _____

Length of Employment: _____

Party responsible for payment: _____ Phone: _____

Address:_____

City State ZIP

Spouse's Monthly Income (if Applicable): _____

Other sources of income (child support, alimony, trust fund, loans, investments, etc.): _____

_____

Amount of other income available: _____

Estimated average monthly expenses: _____

Preferred method of payment: Cash/Check _____ **Credit Card** _____

Please explain the reason for requesting alternative financial arrangements: _____

_____

_____

How long do you anticipate the need for these arrangements? _____

I give Dr. Mustin's office permission to contact my employer or representative thereof to verify my income and benefits.

_____ _____

Signature **Date**

Are you planning to file claims for reimbursement with your insurance company?_____

Insurance Company: _____

Address: _____

_____

City State ZIP

Phone:_____ **Name of insured:**_____

Insured's Name: _____

Plan #:_____ **Group #:**_____

I hereby authorize Jan Ford Mustin, Ph.D., P.C. and staff to contact my insurance company to obtain information necessary for financial arrangements. I understand that this information is strictly confidential and to be used only for the purposes of determining the most appropriate financial arrangements for my therapy.

I herby attest that all information on this form is accurate and that I have honestly presented a thorough picture of my financial situation. I understand that financial arrangements for professional services will be based on this information and that those arrangements are subject to change at any time. I further agree to notify Dr. Mustin's office if and when any of this information changes.

Signature of Client: _____ Date: _____

Witness:_____ Date: _____