Pamela Malkoff Hayes

Art Therapist and Marriage Family Therapist

818-836-1239

HayesArtTherapy@gmail.com

CONFIDENTIAL CLIENT INFORMATION

Name:_____
Last First Middle

Address:_____

_____
City State Zipcode

Mobile Phone _____Home _____

Email: _____

EMERGENCY CONTACT

Name: _____
Last First Middle

Mobile Phone _____Home _____

Email:
_____

PARENT/GUARDIAN (If under 18 year old)

Name:_____

Financial Agreement and Authorization or Treatment

I hereby authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I understand that all charges are due and payable at the end of each session, or at the latest upon presentation of the statement for those charges. I agree that all charges shown on those statements shall be deemed to be correct and reasonable, unless I make a written protest of the charges within 30 days of the billing date. I agree that the charges will be subject to a late charge of 1.5% per month on the unpaid balance. Balancers that exceed 120 days shall be turned over to a collection company and you will additionally be liable for any fees charged by that collection company. Please be aware that this may negatively impact your credit.

I understand the full charges will apply for appointments not kept or canceled with less than 24 hours notice. Canceled sessions are not billable to insurance companies, and therefore, must be paid by the patient prior to the next session.

Payment is due at the time of the appointment.

Sessions are 50 minutes.

I have read the rules of confidentiality provided by this office.

SIGNATURE:

_____

Name Date

I gave my permission to have my artwork reproduced and used for educational purposes only-with my name deleted.

_____

Name Date