AGREEMENT TO PAY FOR PSYCHOLOGICAL ASSESSMENTS

I agree to pay for the services rendered by the The Scott Group, PLLC, as indicated below.

Date of Service _____ _____Payment in Full

Date to be Paid _____

Payment Schedule as Follows:

Date _____ Amount to be Paid _____

Date _____ Amount to be Paid _____

Date _____ Amount to be Paid _____

_____ Payments will be made by Cash or Check

_____ Payments will be made by Credit Card

Credit Card: Visa MasterCard American Express Other

_____ _____
Card Number Expiration Date

_____
Name as appears on card

It is understood that if the patient misses payment, without prior notification and agreement, the practice reserves the right to transfer collections to a collection agency.

_____
Name of Patient

_____

_____
Patient Address

_____
Phone

_____ _____
Patient Signature Date