

Cornerstone Counseling and Education

859 S Yellowstone Hwy Suite #304, Rexburg ID 83440

Phone: 208-313-7464 Fax: 208-907-0972

THIRD PARTY ASSISTANCE AGREEMENT

Client Name DOB

Third Party Information

Name [Printed] _____ Date _____

Relationship to Client

Address _____ Phone _____

Emailed Receipts?

I will be paying via check. I acknowledge that the invoices are mailed at the beginning of each month and payment is due by the 25th of each month. Unless, another arrangement has been made.

I will be paying via a credit card. Credit card payments are automatically processed once a week for individual therapy sessions. Please use the card below.

Name on Card:

Card Number:

Expiration Date:

Security Code:

Billing Address for Card: _____

City: _____ State: _____ Zip: _____

I agree to pay \$_____ /session for individual therapy until _____ [date] or until they have completed _____ [number of sessions].

If the client needs further financial assistance after these terms have been met, it is their responsibility to obtain a new agreement.

Third Party Signature

Date

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**If you wish to further customize this agreement, please explain
the terms below:**

Itemized Costs that May Apply to the Agreement:

1. **Individual Therapy** sessions may vary by cost depending on the insurance plan that covers the client and if they have deductibles or copays. If they are not covered by insurance, the direct pay rate is \$100/session.