Sterling Behavioral Health Services, LTD

20905 Professional Plaza Suite 220 Ashburn VA 20147

Sterling Behavioral Health Services Financial Agreement

Patient/Responsible Party	
Street Address:	
City/State/Zip:	
Social Security Number:	
Date of Birth:	
Home/Work/Cell Phone:	

Services Billed

Dates Of Service:	
Total Amount of debt:	

Payment Schedule

Down Payment:	$0	Due on:	Due on:	$0	Due on:	$0
First Payment:	$0	Due on:	Due on:	$0	Due on:	$0
Second Payment:	$0	Due on:	Due on:	$0	Due on:	$0 Last Payment
Third Payment:	$0	Due on:	Due on:	$0		

Financial Agreement

I agree that the above debt is valid. I agree to have this account paid by the agreed end date set forth by SBHS.

I understand that my refusal to sign this agreement will not prevent me from receiving any MEDICALLY NECESSARY care.

I agree that SBHS may charge me **1.5% Interest Per Month** on any remaining balance if I am late on any payment.

I understand that if I am more than **30 days late** on any payment that I will be in default of this agreement and that SBHS may turn the account over to a collections company if I do not call within **2 business days** of my default.

I understand that **I will be responsible** for any charges associated with collections for this debt.

I understand that this agreement is not ratified until approved by the President & CEO of SBHS.

_____ **My initials** signify that SBHS may use the below **listed Credit Card** to make these payments per the above schedule.

Name on the card	Card Number OR Electronic. Check	Expiration Date & Code on Back of Card
		/

Responsible Party	Date
Witness	Date
President and CEO of SBHS	Date

Payment is due by the 15th of each month.

Office# 703-858-9841 Fax# 703-858-9446