

Family Resource Assoc., Inc.

TECHConnection

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TAX ID#: 22-2285850
NPI#: 1083858575

SELF PAY AGREEMENT

Client Name: _____

Address: _____ City: _____ State ____ Zip _____

Phone: _____ Work: _____ Cell: _____

Date of Birth: _____

I understand I am responsible for the full cost of services for an Alternative Augmentative Communication (AAC) Evaluation and/or therapy services that may follow the evaluation. I also understand that payment is due when services are rendered.

The self-pay discounted rate is \$528 for a 2-hour AAC Evaluation.

When applicable, travel is billed separately at a rate of \$35 per half hour. I understand that travel fees are not generally reimbursed by insurance.

Name of Responsible party:

Date

Signature