**Co-Pay/Payment Plan Agreement**

I understand that per my agreement with my insurance company, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as well as with Stepping Stones ABA, Inc, the provider of services, that I am responsible for paying a copay for services rendered. Payment is due in full at time of service or upon receipt of a monthly bill from Stepping Stones ABA, Inc. In the case of financial hardship, Stepping Stones ABA, Inc. agrees to develop a payment plan to ease the financial burden.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to pay Stepping Stones ABA $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per month until the entire copay bill is satisfied. Termination of services does not void the outstanding amount and I understand I will continue to make payments until the bill is paid in full.

Stepping Stones ABA, Inc. agrees to bill \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in a timely manner and keep a running account of payment owed. Failure to make payments two months in a row without an amendment to this agreement will result in termination of services. I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree that Stepping Stones ABA, Inc. will continue to bill me until the full amount is satisfied.

Client/Guardian Name

Client/ Guardian Signature Date

Stepping Stones ABA Representative signature Date