



DEVELOPMENTAL THERAPY CENTER

3731 SIXTH AVENUE, SUITE 103  
SAN DIEGO, CALIFORNIA 92103

PHONE: (619) 295-4500  
FAX: (619) 278-0885

**FINANCIAL AGREEMENT**

**Please initial**

\_\_\_\_\_ I hereby authorize Developmental Therapy Center to: (choose one) ( ) bill my insurance company, ( ) bill the San Diego Regional Center, or ( ) bill me for therapy received for my child.

\_\_\_\_\_ I understand that I will be responsible for any payment/deductible not covered by my insurance company.

\_\_\_\_\_ I understand that I will be held responsible for assuring that my insurance and prescriptions are in good standing at the beginning of each treatment month.

\_\_\_\_\_ I understand that it is my responsibility to inform Developmental Therapy Center of any changes that may occur in my insurance coverage.

I certify that I have read and understand the above and authorize the initialed consent as of the date below.

\_\_\_\_\_

Child's Name

\_\_\_\_\_

Name of Parent/Guardian

\_\_\_\_\_

Relation to child

\_\_\_\_\_

Signature of Parent/Guardian

\_\_\_\_\_

Date