

Alliance for Eating Disorders Awareness Psychological Services
1649 Forum Place, Suite 10
West Palm Beach, Florida 33401

FINANCIAL STATEMENT

1. What is your annual household income?

- Less than \$10,000
- \$10,001 to \$25,000
- \$25,001 to \$40,000
- \$40,001 to \$55,000
- Over \$55,001

2. Do you currently maintain health insurance?

- Yes. What type? _____
- No

3. What dollar amount are you able to pay for your therapy session?

\$ _____ .00

I hereby certify that the above statements are true and correct to the best of my knowledge. I understand that a false statement may disqualify me from obtaining treatment at The Alliance for Eating Disorders Awareness Psychological Services.

Dated this _____ day of _____, 20_____.

Patient (Print)

Patient (Signature)

Witness (Print)

Witness (Signature)