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INFORMED CONSENT FOR SOMEONE OTHER THAN THE
CLIENT TO ASSUME RESPONSIBILITY FOR PAYMENT FOR
PSYCHOTHERAPY/EFT/NEUROFEEDBACK SERVICES

I _____ (print name of payor) consent to pay for
psychotherapy/EFT/Neurofeedback (circle one) services for
_____ (print client's name) as of _____ (print
date) until otherwise specified.

I understand the following terms apply to this agreement.

1. Payment will be made at the time that service is provided included all missed appointments unless otherwise agreed on.
2. The fee for psychotherapy/EFT/Neurofeedback, psychological testing, and interpretation, consultation, letter or report writing is \$_____ per 45-50 minute session or block of time unless otherwise specified.
3. Services will be terminated and client will be referred out to another provider if payment is not made as agreed upon by this consent.
4. Consent to assume financial responsibility for these services does not entitle the third-party payor to any interview or phone contact with the psychotherapist, or access to any confidential information that is shared within the therapeutic relationship.
5. A statement will be provided suitable for presenting to your insurance carrier for possible reimbursement, if needed.

Signature of Client

Date

Signature of Payer

Date