HOLISTIC PSYCHOTHERAPY OF MARIN

Informed Consent to Assume Responsibility for Payment for Psychotherapy Services: Third Party Payer Form

I, _____ agree to pay for psychotherapy services

and other clinical services for _____ according to the fee agreement between the therapist and the client.

I understand the following terms apply to this agreement:

- Payment will be made as follows ; (check one):
  _____ At the time of service
  _____ Within two weeks of receiving an invoice
  _____ Others (specify): _____
- The fee for psychotherapy, psychological testing and interpretation, consultation, letter or report writing or other clinical services is $ _____ per _____ minute session unless otherwise specified. For more details, see previous informed consent.
- Please inform the therapist ahead of time or as soon as you know if there are changes in your ability or willingness to pay.
- Services will be terminated if timely payment is not made as agreed to by this consent.
- Consent to assume financial responsibility for these services does not entitle the third-party payer access to confidential information unless agreed in writing otherwise by the named above patient.
- Upon your request and upon obtaining client's written permission, if appropriate, you will be provided with an invoice/super bill, which is suitable for presenting to your insurance carrier for possible reimbursement. Not all conditions are reimbursable.
- This agreement supplements previous informed consents.

Signature of Client:_____Date:_____
Signature of Payee: _____Date:_____