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Informed Consent to Assume Responsibility for Payment for Psychotherapy Services

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

  _____ Payment will be made by credit card, cash, zelle or cashapp at the time of service

- The fee for psychotherapy, psychological testing and interpretation, consultation, letter or report writing or other clinical can be found on the fee schedule. For more details, see previous informed consent. Please sign below to indicate you have seen, read and signed the fee schedule for NewPoint of View Counseling.
- X
- Please inform the therapist 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 otherwise agreed in writing by the above-named client.
- Upon your request and upon obtaining the client's written permission, if appropriate, you will be provided with a 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: _____

Signature of Therapist: _____ Date: _____