Evolve Counseling, PLLC

P.O. Box 152
Selmer, TN 38375
(731) 610-8862

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

  _____ Within two weeks of receiving an invoice

  _____ Other (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 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.

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Signature of Client: _____ Date: _____

Signature of Payee: _____ Date: _____