CAROL UMMEL LINDQUIST, PH.D., FACLINP
CLINICAL PSYCHOLOGIST

THE PSYCHOLOGY CENTER
380 GLENNEYRE SUITE D
LAGUNA BEACH, CA 92651

INFORMED CONSENT FOR PARENT OR THIRD PARTY TO ASSUME RESPONSIBILITY FOR PAYMENT OF PSYCHOTHERAPY SERVICES

I _____ consent to pay psychotherapy services
(Print name of payor)

for:

_____.
(Print name of client)

I understand the following terms apply to this agreement.

1. Payment will be made ***at the time that service is provided by cash, check or credit card on file.***

2. The fee for psychotherapy, psychological testing and interpretation, consultation letter or report writing is $250.00 per hour unless otherwise specified.

3. Services will be terminated if payment is not made as agreed to by this consent.

4. Consent to assume financial responsibility for these services does not entitle the third party payer to any interview or phone contact with the therapist or access to any confidential information that is shared within the therapeutic relationship unless agreed to by client and therapist in advance.

5. In case of an adolescent or child the parent has a right to know whether the client attends and participates but not the content of the sessions unless the minor chooses to reveal this information. Exceptions will be discussed in advance with the minor but exclude danger to self or others that would require me to break confidentiality.

6. A bill will be provided suitable for presenting to your insurance carrier for possible reimbursement.

_____

Signature of Client Date

_____

Signature of Payor Date