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

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

PARENT OR THIRD-PARTY AGREEMENT TO ASSUME RESPONSIBILITY FOR PAYMENT OF PSYCHOTHERAPY SERVICES

I ____ agree to pay for the psychotherapy services
(Print name of person assuming responsibility)

for: (Client) ____
(Print name of client receiving psychotherapy services)

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 current 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 agreement.

4. Agreement 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 a 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. In any case, where there is danger to self or others the therapist is obligated share this information with appropriate parties.

6. The office does not accept or bill insurance. However, a bill will be provided suitable for presenting to your insurance carrier for possible reimbursement.

X ____
Signature of Client Date

X ____
Signature of Person Assuming Responsibility Date

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