Informed Consent to Assume Responsibility
for Payment for Psychotherapy Services
Angela Nock PLLC

I, __________________________________ agree to pay for psychotherapy services
and other clinical services according to the fee agreement between Angela Nock, M.A. 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 $ 80.00 per
50 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 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 ____________