MEN & HEALING

PSYCHOTHERAPY FOR MEN

INFORMED CONSENT TO ASSUME PAYMENT RESPONSIBILITY

Organization

I _____ (Primary Contact Name & Job Title) on behalf of _____ (Organization Name), agree to pay for psychotherapy services and other clinical services for _____ (name of client) according to the fee agreement between Men & Healing and the client.

Authorization

I authorize payment for the following services conducted by Men & Healing:

Individual Therapy

☐ As many sessions as the client/therapist deems necessary

☐ No more than _____ (include total) sessions

Group Therapy

☐ A mandatory initial clinical assessment

☐ The next 20 hour group therapy program:

Individual sessions unattended, or cancelled without 48 hours notice, by the client, will be charged at the full amount. Unattended group sessions will not be reimbursed or credited.

By initialling each line below, I understand:

The fee for psychotherapy is in accordance with the current rates as listed on our website.

If desired, the fee for consultation, letter or report writing, or other clinical services, is in addition to psychotherapy fees and will be charged in accordance with the current rates as listed on our website.

On behalf of my organization I will be issued an invoice. Alternatively, I will provide credit card information, which will be retained and from which payment will be taken at the time services are rendered, or at committment to group therapy.

Payment will be made on receipt of invoice.

I will inform Men & Healing ahead of time or as soon as I know of any changes in my organization's ability or willingness to pay.

Consent to assume financial responsibility for these services does not entitle the primary contact or organization access to confidential client information.

Upon completion of services the organization will be issued a receipt.

This agreement supplements previous informed consents.

☐ **Invoice** **Billing Information:**

_____ Primary Contact Name

_____ Organization Name

_____ Primary Contact Email

_____ Primary Contact Phone Number

_____ Full Mailing Address of Organization

☐ **Charge** **Credit Card Information:**

_____ Name on Card

_____ Credit Card Number

_____ Expiration Date

_____ CVV Number

_____ Full address associated with the card

The organization will be contacted only in regards to payment issues. Any payment issue that may interfere with the client receiving services will also be communicated with the client.

Please send completed form to info@menandhealing.ca or fax to (613) 701-0379