



Third Party Payment Form

Informed consent to assume payment responsibility for therapy.

I _____ (Full Name) agree to pay for the Therapy services for
_____ (Full Name) according to the fee agreement between the
therapist and client.

I understand the following terms apply to this agreement;

- The fee per session is £XX per 50 minute session unless otherwise specified.
- Please inform Claire Huzzey (The Therapist) ahead of time or as soon as you know if there are changes in your ability or willingness to pay.
- Sessions will be terminated if payment of fees is not made as per agreed with this consent.
- Consent to assume financial responsibility for therapy services does not entitle any third-party payer access to confidential information unless agreed in writing to myself from the above-named client.
- I agree for payments to be made in accordance to the therapy agreement prior to the commencement of the therapy session.
- I understand I am liable to the payment of the above client's session in relation to the therapist's cancellation policy.
- Cancellation policy - A minimum of 48 hours' notice should be given in the event of needing to cancel a session. If less than 48 hours' notice is not received partial payment will be required. If less than 24 hours' notice is given full payment will be required.
- **Bank details:** Sort code:
Account Number:
Account Name:

Sign (Third Party):

Date:

Client:

Date: