Cathy Fariss, MA, LPC
4131 Spicewood Springs Rd. Ste. K-6
Austin, TX 78759
(512) 577-9932

RESPONSIBILITY FOR PAYMENT BY A THIRD PARTY

I agree to accept responsibility for the payment of all professional fess incurred for services provided to the following client: _____. I have read and understand the office policies described on a separate form. I understand that this agreement does NOT constitute a waiver of confidentiality between the therapist and the client, except as specifically authorized by the client below.

Signature: _____ Date: _____

Name and Address: _____

_____

_____

Telephone: Home: _____ Work: _____

TO BE COMPLETED BY THE CLIENT: I request and authorize Cathy Fariss to release information concerning billing, payments, fees, insurance, appointment dates, and missed sessions to the individual names above.

Signature: _____ Date: _____