Consent to Treatment - Adult

I agree to engage in counseling services at Daylily Health. My rights and benefits associated with treatment have been explained to me and I understand my therapist may discontinue treatment at any time. I agree to discuss any change in services with my therapist. _____**initials**

Non-discriminatory Practices

Daylily Health ensures that members are not discriminated against or denied services due to race, ethnicity, national origin, religion, sex, age, mental or physical disabilities, medical conditions, sexual orientation, claims experience, medical history, being uninsured, and/or genetic information.

Out-of-Pocket Fees

I understand that I am financially responsible for all out-of-pocket expenses. I agree to pay the full client fee for services rendered in the amount of _____ for Intake and _____ per session. I understand I am responsible for all charges. I understand payment is due before the start of session. Additionally, I acknowledge that if payment is not received in full after 30-days the balance due will be forwarded to a collection agency for payment resolution. _____**initials**

Health Insurance Assignment and Release

I, the undersigned, certify that I have insurance coverage with_____ and assign directly to Daylily Health all insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand that it is my responsibility to pay any deductible amount, co-insurance, or balances not paid by my insurance company. If my insurance company does not pay within 120 days, I understand I am responsible for all charges and Daylily Health will provide receipts so that I may contact my insurance company.

Additionally, I acknowledge that if payment is not received in full after 30-days the balance due will be forwarded to a collection agency for payment resolution. I hereby authorize Daylily Health to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. _____**initials**

I have read, understand, and agree to these policies.

_____ _____

Print Name **Signature**

_____

Date

_____ _____ _____

Office Staff **Date** **Time**