Consent to Treatment - Minor

I agree to allow my child to engage in clinical services at Daylily Health with and/or without my presence during the session. I understand that I am the holder of confidential privilege-the right to withhold disclosure of private counseling information about my child. However, in the interest of developing a trusting relationship between the therapist and my child, I give the therapist permission to reveal or withhold information that in her clinical judgment is necessary to best help and protect my child.

My rights and benefits associated with treatment have been explained to me and I understand the therapist may discontinue treatment at any time. Any change in services will be discussed by my therapist.

I understand that if my child is under the age of 15, I must stay at Daylily Health during their entire session. _____initials

Non-discriminatory Practices

We at Daylily Health ensure 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, or being uninsured, and/or genetic information.

Health Insurance Assignment and Release

I, the undersigned, certify that my dependent has 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, other balances not paid by my insurance company, or pay the full client fee if I have no insurance coverage. In the event that my insurance company does not pay within 120 days, I understand that I am responsible for all charges and Daylily Health will provide receipts so that I may contact my insurance company.

Also, if I agree to pay Daylily Health out-of-pocket, I am responsible for all charges. 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 Parent/ Guardian Name **Print Name of Child**

_____ _____

Parent or Guardian Signature **Date**

_____ _____ _____

Staff Signature **Date** **Time**