Daniel L. Richards, Ph.D., LCPC

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Consent for payment from insurance company

I, the undersigned, authorize Daniel Richards PhD., LCPC to bill and receive payment from my insurance company for the dates of services that I have with him. Daniel Richards PhD., LCPC agrees as a contract provider for my insurance company to accept a fee in accordance with the insurance company guidelines and hold me responsible only for the co pay as specified by my insurance company. I understand and agree that if my insurance company benefits expire or further sessions are not authorized I will become responsible for Daniel Richards PhD., LCPC full fee for any subsequent sessions. I further understand and agree that if my insurance company should refuse a payment for services and Daniel Richards PhD., LCPC can not resolve the dispute on my behave I become responsible for the full fee for that session. I agree that I will notify Daniel Richards PhD., LCPC of any changes in my insurance and be responsible for any initial authorization.

I, the undersigned, understand that I may revoke this consent at any time during my treatment with Daniel Richards PhD., LCPC, except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire when treatment with Daniel Richards PhD., LCPC ends, or my insurance changes. If I do revoke this consent I understand and accept that I will be responsible for Daniel Richards PhD., LCPC full fee. In giving this release I am hereby releasing Daniel Richards Ph.D., LCPC from any and all liabilities, responsibilities, damages and claims which arise from the release of information authorized.

I_____, DOB_____, SS#_____

( ) I have read and understand the above information and give my consent

( ) I do not give my consent to release or inform my insurance company of my treatment with Daniel Richards PhD., LCPC, and I understand I will be responsible for the full fee for each session

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Client Signature Date