



Adult Consent for Services

By signing this agreement you are giving consent to receive therapeutic services from Brighter Futures Counseling, PLLC.

****Please do not hesitate to ask any questions at any time. ****

Client Name: _____

Date of Birth: _____

SS#: _____

My signature below means that I consent to be treated and have read and agree to all of the points described in the Professional Services Agreement of Brighter Futures Counseling, PLLC.

I also understand that I am responsible for paying my copay, co-insurance and any amount applied to my deductible as well as any payment that my insurance company denies or misquotes to Brighter Futures Counseling. It is my responsibility to understand the mental health benefits provided under my insurance policy.

I also understand that if I miss or cancel 3 or more appointments within 24 hours of the appointment time, for a non-emergency reason, I will be billed \$20.

Client Name (Print)

Date

Client Signature

Date

Witness

Date