CONSENT TO TREATMENT

Please Complete This Page

Name of Client: _____

- I have read, understand, and been given a copy of the Client information on Office Practice and Policies
- I have signed a copy of the Notice of Privacy Practices (HIPAA-related)
- I give my consent to treatment by Dr. Beverly Davis
- If I want to use insurance, I authorize Dr. Beverly Davis to file for my insurance and to accept assignment of insurance payment for her services unless otherwise specified above
- I understand that if I use insurance, Dr. Beverly Davis may be required to communicate with representatives of my insurance carrier.
- If my insurance company or managed care company does not cover services I realize that I am responsible for all fees for services provided
- If I have any concerns or complaints about my treatment, I understand I should talk with Dr. Beverly Davis regarding them.

Client Signature _____Date _____

I further consent to the evaluation and/or treatment of my minor child in my legal custody or guardianship.

Signature of Guardian (if applicable)

_____Date _____

Signature of Dr. Beverly Davis

_____Date_____