Holly Shaw PhD LPC
2629 Redwing Road, Suite 305
Fort Collins, CO 80526
970-266-8062

INFORMED CONSENT SIGNATURE PAGE

Name of Client ____ **Date of Birth** _____________

Parent or Guardian (if client is a minor): ____

- The form of payment will be ___ Self Pay, ___ Insurance.
- If the payment is Self Pay, the session fee will be ___ per session, due at the time of service.
- If the payment if insurance, the copay is ___ and is due at the time of service. Please confirm, there ___ is, ___ is not a deductible still due at this signing. If there is a deductible due, full session payment of ___ is due at the time of service.
- If payment is insurance, if payment is denied by insurance for any reason, the client is responsible for full payment.

By signing below, I am indicating that I have read, understand, and agree to the information contained in the **INFORMED CONSENT** document, and I have received and reviewed a copy.

I acknowledge that I have received the information listed above from Holly Shaw PhD LPC. I understand that I can discuss any questions I have about the procedures at that time.

____ ______________________
Signature of client Date

____ ______________________
Holly Shaw PhD LPC Date

INSURANCE AUTHORIZATION/RELEASE OF INFORMATION
(Signature necessary only if using insurance to pay for services)

By signing below, I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of insurance benefits to Holly Shaw PhD LPC.

____ ______________________
Signature of client Date

Name of Insured for Insurance ________________________________
Date of Birth for Insured: ________________