

Caring Therapy Services, PLLC - Virginia

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PATIENT CONSENT FORM

NAME	
ADDRESS	
ADDRESS	
PHONE	
EMAIL	
DOB	
SSN	
GENDER	
INSURANCE	
POLICY #	
GROUP#	
EMER CONTACT	

CONSENT FOR TREATMENT: I voluntarily consent to receive evaluation, mental health treatment, eating disorders, coaching & counseling as deemed clinically and medically necessary from the above named practice. I will participate with my treatment plan of care as drawn up by said clinicians.

CONSENT FOR PAYMENT: I voluntarily consent for my insurance to be accessed for payment. Should any fees (co-pays, no-show fees or unpaid balance) be invoiced to me, I will pay by PayPal.

SIGNATURE

DATE