INNER LIGHT COUNSELING AND HOLISTIC CENTER

Insurance Changes

I _____, agree that should my insurance cease or change, I am to notify the office administrator before said changes take place.

I agree should I fail to notify Inner Light Counseling of these changes, I would be financially liable for all services that have been provided and not covered by my previous insurance at a rate of $100.00 per visit not covered.

Client Signature: _____

Therapist Signature: _____

Date: _____