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Signatures

I understand that if I use insurance, Dr. Cadenhead 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 that I should talk with Dr. Cadenhead regarding them.

_____ _____
Client Signature Date

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

_____ _____
Signature of Guardian (if applicable) Date

_____ _____
Signature of Dr. Cadenhead Date

PLEASE COMPLETE THIS PAGE