



## Non-Credentialed Provider Consent

I verify that I have been informed that (Provider Name/Credentials) \_\_\_\_\_ is not currently credentialed by my primary insurance company. Because of this, services will be provided under the supervision of a fully credentialed provider within my insurance network. I will contact my insurance company for further information, if needed.

\_\_\_\_\_  
Signature of Client, Parent, or Legal Guardian

\_\_\_\_\_  
Date