Sankofa Counseling
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I understand that by signing this form I am waving my rights to use my insurance. I do not permit Sankofa Counseling – Amanda M Wyatt, LLC to submit claims for payment to my insurance company. I _____ am choosing to opt out of billing my insurance, which is _____. I agree to pay the amount of _____ per session.

Signature of Patient/ Parent/ Legal Guardian Date

Printed Name Relationship to Patient

Signature of Clinician Date