# CONSENT FOR NON-CREDENTIAL PROVIDER

I, _____, acknowledge the awareness that I will receive outpatient mental health services at Hope Therapeutic Services, from a mental health practitioner who is not credentialed by my health plan. However, I understand these services will be under the professional supervision of a licensed provider who is credentialed by my health plan and my health plan's supervisory protocol will be followed.

By signing below, I give my consent to being treated by a non-credentialed provider.

_____ _____
Signature of Person Giving Consent Date

_____ _____
Parent/Guardian Signature Date
When Legally Required

_____ _____
Signature of Person Informing You of Your Rights Date

Name of Health Plan: _____



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