

# UBH Consent Form for Non-Credentialed Providers

Client Name: \_\_\_\_\_

Therapist Name: \_\_\_\_\_

Clinical Supervisor: \_\_\_\_\_

**I have been informed that the therapist providing services for me is not credentialed by my insurance provider and is currently under the supervision of a UBH credentialed provider. However, I further understand that this will be reimbursed as an in-network service.**

\_\_\_\_\_  
**Patient Signature** \_\_\_\_\_  
**Date:**

\_\_\_\_\_  
**Parent/Guardian Signature** \_\_\_\_\_  
**Date:**