LORETTA M. LOWERY, LCSW
SELF PAY AGREEMENT

Client's Name: _____

With my signature and my initials below, I verify that:

_____ I do not have insurance coverage.

_____ I have insurance coverage but choose not to use it. I understand that in doing so, I am waiving my right to all future reimbursements. And agree not to bill my insurance company for services.

_____ I have insurance coverage but understand that the services provided are not covered by my plan.

Client Signature: _____

Date: _____