



Jessica Sauer, LCSW
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INSURANCE WAIVER AGREEMENT

I, _____ for _____,
(Print Your Name as a Consenting Adult) (Print Name of Client)

understand that I am responsible for any charges for psychotherapy services provided by Jessica Sauer, LCSW of Brand New Day Counseling, LLC according to the financial policy. I agree to pay \$____ per session. I further acclaim that I do not have mental health insurance coverage, or if I do, have chosen not to utilize my health insurance plan. If the latter is true, then I understand that my insurance company will not reimburse me for any or all of my fees, and Brand New Day Counseling, LLC will not be responsible for any charges that are not reimbursed by my insurance company. I choose to pay for the psychotherapy services out of pocket, and at the time that services are rendered.

This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

Signature/Relationship to Client _____ Date _____

Effective 12/10/2024