Megan W. Spinks, LCSW, ACSW, Inc.
6408 Constitution Drive Fort Wayne, In 46804
(260) 459-0990 Fax: 459-0282

Consent for Services

Please initial and sign below consenting for treatment of mental health services.

_____ **Responsibility for Charges Incurred**

All insurance co-pays, co-insurance, and/or deductible amounts are due at the time of service. I agree that I am responsible for charges incurred after all insurance payments have been made. I understand I am responsible for the entire amount of services in the event I do not provide accurate information related to my insurance information. I understand that there is a $30.00 return check fee charge.

_____ **Agreement to Pay**

In consideration for the services rendered and to be rendered by Megan W. Spinks, LCSW, ACSW Inc. to the below mentioned patient, I agree to pay Megan W. Spinks, LCSW, ACSW, Inc. for all services and charges in accordance with the terms and policies of Megan W. Spinks, LCSW, ACSW, Inc... I further agree and guarantee that in the event the account is not paid in accordance with the financial arrangements made or within sixty (60) days from the date of service and it is necessary to place this account in the hands of a collection agency, to pay cost of collections which includes: 35% of the outstanding balance, court costs, collection fees and interest from the date of demand.

_____ **Assignment of Payment**

I assign all treatment benefits which are due for services to Megan W. Spinks, LCSW, ACSW, Inc. be paid directly to Megan W. Spinks, LCSW, ACSW, INC..

_____ **Failed Appointment Charges**

I understand that 24 hour notice is required for cancellation of appointments. A failed or no show appointment is defined as a cancellation that is not done within 24 hours of the appointed time. I understand that if I fail to cancel my appointment within 24 hours or if I do not show for a scheduled appointment, I am responsible for the full $90.00 fee for the session, which will be due prior to the next scheduled appointment.

_____ **Treatment of Choice**

I understand that I have chosen to be involved in counseling services. I have the right to be actively involved in my treatment goals and can ask questions at any time. I understand that I may terminate treatment at any time.

_____ **Additional Fees**

I understand there will be a charge for any letters/summaries required during my care. This includes letters to schools, attorneys, and outside professionals. I understand fees for consultation to attorneys will occur.

_____ **Release of Medical Information/HIPPA**

I authorize, Megan W. Spinks, LCSW, ACSW, Inc. to release necessary medical information to the appropriate third parties for reimbursement purposes and/or persons authorized to conduct utilization review services. I have been offered HIPPA privacy rules and regulations.

I agree and consent to participate in services provided by Megan W. Spinks, LCSW, ACSW INC. as defined by the laws of Indiana. I understand that I am consenting and agreeing to counseling services by a licensed counselor in the state of Indiana.

Patient Name if child:____

Client/Responsible Party: ____ Date: ___________

Witness: ____ Date: ___________