Creative Counseling and Coaching LLC
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CONSENT FORM

Patient Name:_____

In the event we need to contact you with information what is the best phone number to reach you:
_____

Can we leave a voicemail message: yes or no?
Can we leave appointment information: yes or no?

Emergency contact name_____
Relationship:_____
Emergency contact phone number:_____

Please read and initial statements below (Parent/Guardian if patient is under 18)

_____I understand I am responsible for all copays, co-insurances and/or deductibles due at the time of visit

_____I understand that I am responsibel for payment for the following services not covered by my health insurance. Such as reports, letters, correspondences with schools or employment, FMLA paperwork and disability assessments, . Also including but not limited to other third party requests.

_____ I understand that is is my responsibility to keep Marsha Magun LPC informed of any changes insurance, billing, and contact information. Failure to do so may lead to insurance claim denials and payments on my account balances. The account balance will then be my responsiblity.

_____I understand if I write a check for services and it is returned for insufficeint funds or the accound being closed, there will be a fee assessed by Marsha Magun LPC for the returned check and payment in full plus the fee will be expected before scheduling another appointment.

I_____do hereby give authorization for direct payment from my insurance company to Creative Counseling and Coaching LLC. I also authorize Marsha Magun LPC to furnish any information regarding my illness, care, and treatment to my insurance company and/or attorney when requessted.

Patient/Guardian Signature:_____Date:_____