AUTHORIZATION FOR FILING INSURANCE

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION TO PROCESS INSURANCE CLAIMS. I AUTHORIZE THE PAYMENT OF MEDICAL BENEFITS TO MARSHA MAGUN, LPC

SIGNATURE_____DATE_____

AGREEMENT TO PAY FOR TREATMENT

CANCELLED AND MISSED APPOINTMENTS

IF THE COST OF MY TREATMENT EXCEEDS MY BENEFITS FROM MY INSURANCE COMPANY, TO THE FULL EXTENT CONTRACTUALLY ALLOWED I UNDERSTAND AND AGREE THAT I AM RESPONSIBLE FOR FULL AND TIMELY PAYMENT.

I AGREE TO CANCEL APPOINTMENTS NO LESS THAN TWENTY FOUR HOURS PRIOR TO THE APPOINTMENT TIME. IF I DO NOT GIVE TWENTY FOUR HOURS NOTICE I UNDERSTAND THAT I WILL BE CHARGE $150.00 MISSED APPOINTMENT FEE.

ILLNESS AND OTHER SITUATIONS BEYOND MY CONTROL WILL BE GIVEN DUE CONSIDERATION ON A CASE BY CASE BASIS.

MISSED APPOINTMENTS OR APPOINTMENTS CANCELLED WITH LESS THAN 24 HOURS