



Marsha Magun L.P.C, A.T.R

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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 responsible 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 it 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 responsibility.

_____ I understand if I write a check for services and it is returned for insufficient funds or the account 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 requested.

Patient/Guardian

Signature: _____ **Date:** _____