Margaret L.Coats, Counseling Inc.
Margaret L. Coats, LMHC, RN, CADACII
6525 Constitution Drive, Fort Wayne, In 46804
Phone: 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.

_____ **Assignment of Payment**

I assign all treatment benefits which are due for services to Margaret L. Coats, Counseling, Inc. be paid directly to Margaret L. Coats, Counseling, Inc.

_____ **Failed Appointment Charges**

I understand that 24 hour notice is required for cancellation of appointments. A failed appointment is defined as a no show or a cancellation that is not done so within 24 hours of the appointed time. I understand a $50.00 no show charge will be charged to my account and due at 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.

_____ **Release of Medical Information**

I authorize, Margaret L. Coats, Counseling Inc., to release necessary medical information to the appropriate third parties for reimbursement purposes and/or persons authorized to conduct utilization review services.

_____ **Supervision of Cases**

In the event that my insurance requires supervision by a psychologist, I understand and consent that Richard Hite, Ph.D., will provide supervision for my case.

I agree and consent to participate in services provided by Margaret L.Coats, Counseling, 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.

Client/Responsible Party: _____ Date: _____

Witness: _____ Date: _____