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

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 are made. In the event I do not provide accurate insurance information, I understand I am responsible for the full fee for service provided. I understand that there is a $30.00 return check fee charge.

_____ **Agreement to Pay**

In consideration for 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 during the business week. **Cancellations made over the weekend will be considered late cancellation**. 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 a $90.00 fee for the missed session. This 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 HIPAA 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: _____

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Patient Name: _____ Gender: __ Male __ Female

Address: _____
Street/Box# City State Zip

Cell Phone: _____ Permission to Contact/ Leave Message: __ Yes __ No Initials: _____

Work Phone: _____ Permission to Contact/ Leave Message: __ Yes __ No Initials: _____

Home Phone: _____ Permission to Contact/ Leave Message: __ Yes __ No Initials: _____

Email address: _____

Marital Status: __ S __ M __ D __ W Patient Employer: _____

Patient Date of Birth: _____ Patient Age: _____

Primary Care Physician: _____ Permission to Contact Physician: __ Y __ N Initials: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Primary Insurance Information

Insured's Name (if different from above): _____

Insured's Address: _____
Street/Box# City State Zip

Insured's Social Security #: ______ Insured's **Date of Birth: _____**

Insured Employer: _____ Relationship **to Patient: _____**

Insurance Company: _____ Insurance ID #: _____ Group # _____

Secondary Insurance Information

Insured's Name (if different from above): _____

Insured's Address: _____

Insured's Social Security #: ______ Insured's **Date of Birth: _____**

Insured Employer: _____ Relationship **to Patient: _____**

Insurance Company: _____ Insurance **ID #: _____ Group # _____**

If a Child Is the Identified Client

Father's Name: _____ Stepfather: _____

Mother's Name: _____ Stepmother: _____

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Megan W. Spinks, LCSW, ACSW, Inc.
Authorization for Release/ Exchange of Information

Client Name: _____

Date of Birth:_____

Information Release/ Exchange From:
Facility: Megan W. Spinks, LCSW, ACSW
Address: 6408 Constitution Drive
Fort Wayne, IN 46804
(260) 459-0990

Information Release/ Exchange to:
Facility/Person: _____
Address: _____
Phone :(____) _____

__Intake Education
__Assessment/diagnosis
__Compliance/ Attendance
__Medical Records
__Treatment Recommendations
__Attendance
__Treatment Plan
__Recommendations

__ Progress Notes
__ Progress Reports
__ Medical Tests
__ Psychological Evaluation
__ Psychiatric Evaluation
__ Treatment Prognosis
__ Discharge summary; prognosis
__Other (specify) _____

Purpose or need for such Release/ Exchange of Information:

_____

_____

Authorization to Release/Exchange Information:
I understand that this authorization shall remain in effect for 180 days from the date of my signature below, unless an earlier expiration date is specified in this space ( ). I also understand that except to the extent that action has already been taken based upon this authorization, I may revoke this consent at any time by written notification to this agency.

I hereby authorize the release and /or exchange of the above identifying information from my records. I hereby release Megan W. Spinks, LCSW,ACSW, Inc. from all legal responsibility or liability that may arise from this authorization.

Authorizing Person Signature: Date:

Parent or Guardian Signature: Date:

Witness/Clinician Signature: Date:

This information has been disclosed to you from the records protected by Federal Confidentiality Rules (42 CFR, Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of this person to whom it pertains or as otherwise permitted by 42CFR, part 2. A general authorization is not sufficient for this purpose. The federal rules restrict any of the information to criminally investigate or prosecute any alcohol or drug consumer.

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Cancellation Policy

Cancellations for scheduled appointments require a 24-Hour notice during the business week. **Cancellations made over the weekend will be considered late cancellation and fees will apply.** If 24-hour notice is not given you will be charged a fee of $90.00. A no show for an appointment will result in a fee of $90.00.

Social Media Policy

FRIENDING

I cannot accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy.

COMMUNICATION

TEXTING: Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure, and I may not read these messages in a timely fashion. Do not use Wall postings, replies, or other means of engaging with me. This way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

Please note that if you do choose to utilize SMS to communicate with me, texting does not meet HIPAA privacy requirement and by texting you accept the risk of this. If you do utilize SMS/text please do so only for administrative reasons, such as to change or confirm an appointment.

EMAIL: My email does not meet HIPAA compliance for privacy. If you choose to communicate with me by email, be aware that all emails are retained in the logs of you and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails I receive from you and any responses that I send to you become part of your legal record. I prefer using my email only to arrange or modify appointments. Please do not email me content related to your therapy sessions, as my email does not meet HIPAA requirements for privacy.

At times a client may choose to send information through email such as school testing, emails from schools, work notes, or updates. By signing this, you understand that my email is not HIPAA compliant, and you accept the risk.

I have read and understand social media policy.

Client Name: _____

Responsible Party Signature :(if patient is a minor) _____ Date: _____

Witness: _____ Date: _____