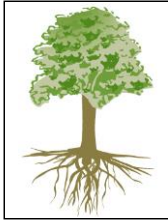

Indiana Professional Psychological Services

6480 Constitution Drive,
Fort Wayne, Indiana 46804

(260) 469-0090 Office (260) 469-0091 Fax

CONSENT FOR SERVICES

Please initial and sign below

_____ *initials*

Treatment Choice / Involvement

I understand I have made a *voluntary choice* to seek psychological treatment. I understand I will be actively involved in forming treatment goals and can inquire about treatment risks and benefits at any time. I understand I may terminate treatment at any time.

_____ *initials*

Release of Medical Information

I authorize Indiana Professional Psychological Services, P.C. (IPPS) to release necessary medical information to appropriate third parties for reimbursement purposes and/or persons authorized to conduct service utilization reviews.

_____ *initials*

Policies and Practices to Protect the Privacy of Your Health Information

I have received a copy of the HIPPA guidelines on *Policies and Practices to Protect the Privacy of Your Health Information* and consent to its provisions.

_____ *initials*

Benefit Assignment

I assign all treatment benefits which are due for services to Indiana Professional Psychological Services, P.C. and authorize those benefits to be paid to IPPS.

_____ *initials*

Failed Appointments: PLEASE READ CAREFULLY

A failed appointment is any appointment *No Show* or *Cancellation* without 24 hour notice. Exceptions include sudden illness and/or emergency situations only, but NOT situations of inconvenience, i.e., work schedule or childcare changes, etc. IPPS reserves the right to make final determination on failed appointments. Insurance cannot be billed for failed appointments**. I understand I will be charged and pay $ 40.00 for the first failed appointment, and the full fee for any subsequent failed appointments. Payment for failed appointments must be made in advance of rescheduling.**

_____ *initials*

Responsibility for Charges

All insurance co-pay, co-insurance, and/or deductible amounts are due at the time of service. I agree I am responsible for any and all allowable charges after final insurance benefits have been posted. I will be billed only when balances are due. If I choose not to use my insurance benefits, or, fail to provide accurate and current insurance documentation, then I will be responsible for the entire cost of services at the time of services. I will be financially responsible to pay any costs incurred in collecting overdue balances, including but not limited to collection fees and/or attorney fees.

I agree and consent to participate in the mental health services offered and provided by my counselor, as defined in Indiana law. I understand I am consenting and agreeing only to those mental health services that my counselor is qualified to provide within: (a) the scope of the provider's license, certification, and training; or (b) the scope of the license, certification, and training of those mental health providers directly supervising the services received by the patient.

Client / Responsible Party: ____ Date: ___________________

Witness: ____ Date: ___________________