CONSENT FOR MENTAL HEALTH SERVICES

I, the undersigned agree and consent to participate in the mental health services offered and provided by Steve Wham, LCSW, a mental health provider or psychologist as defined in Indiana law.

I understand that I am consenting and agreeing to only those mental health services that the above named provider is qualified to provide within: the scope of the provider's license, certification or training or the scope of the license, certification of those mental health service providers directly supervising the services received by the patient

I authorize the above named provider to release medical and/or other information about me as necessary for processing insurance claims for services rendered. It is possible that this service may not be covered by my insurance. If this occurs, I will be responsible for full payment.

_____ _____

Patient/Guardian Signature **Date**

_____ _____

Witness Signature **Date**