WENDELL COUNSELING

CONSENT FOR TREATMENT

Patient Name:_____

I have read the “Practice, Fees, and Payment Policies” handout and understand that I am responsible for full payment at the time of service, that Dane Wendell does not participate with any insurance companies, and that I will be charged for any missed appointments and appointments canceled with less than 24 hours notice.

_____ _____
Signature of patient, parent, or personal representative Date

_____ _____
Printed name of patient, parent, or personal representative Relationship to patient

_____
Signature of authorized representative of this practice
Dane Wendell, LCPC

Wendell Counseling, LLC
Dane Wendell, LCPC
600 Wyndhurst Ave, apt 112
Baltimore, MD 21210
443-862-0892
dwendell@wendellcounseling.com