CLINICAL PSYCHOLOGISTS,P.C.

I have received and reviewed a copy of:

_____YES _____ NO HIPAA Privacy Policy

_____YES _____NO Clinical Psychologists P.C. office policies regarding billing, insurance, missed appointments etc.

Signature_____

Date_____

- **We release only the basic minimum information to your insurance carrier in order to file your claim.**

- **IF YOU DO NOT WANT YOUR INSURANCE FILED PLEASE INDICATE THIS BELOW.**

  I do NOT want my benefits assigned or my insurance filed. Therefore I am fully aware that I am responsible for ALL charges incurred.

Signature_____

Date_____