



Authorizations and Acknowledgements

Patient Name: _____

By signing below, I agree to the following:

- I have read and agree to abide by Clearly Speaking Therapy's policies and understand that I am financially responsible for all charges, regardless of insurance reimbursement.
- I have had the opportunity to receive Clearly Speaking Therapy's HIPAA Notice of Privacy Practices.
- I authorize the release of necessary medical and billing information between Clearly Speaking Therapy, the referring physician, and insurance company for the purpose of processing insurance claims.

Signature

Date

Print Name