# 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

297 Herndon Parkway, Suite 203 Herndon, VA 20170

Phone: 703.435.0488 Fax: 571.323.0030

www.clearlyspeakingtherapy.com info@clearlyspeakingtherapy.com