ClearlySpeaking therapy

Authorizations and Acknowledgements

Patient Name: _____

By signing this statement, I acknowledge that I have read and agree to abide by the policy statement. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____
Authorized Person's Signature Date

_____
Print Authorized Person's Name

By signing this statement, I acknowledge that I have had the opportunity to receive Clearly Speaking's HIPAA Notice of Privacy Practices:

_____ _____
Authorized Person's Signature Date

_____
Print Authorized Person's Name

I hereby authorize the release of any necessary information for insurance claims, including medical and billing information, to/from Clearly Speaking to/from the referring physician and insurance company.

_____ _____
Authorized Person's Signature Date

_____
Print Authorized Person's Name

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