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**Name (printed) Date of Birth**

**Release of Information to Insurance Company(ies)**

Mothering Voice or its contracted billing service may bill the following insurance company(ies) and they may pay the clinic directly. I authorize Mothering Voice to release the necessary information for use by insurance company(ies) for processing claims for treatment and/or for requesting the authorization of additional sessions, including the release of PHI, diagnosis, and clinical information.

**Financial Agreement**

I assign directly to Mothering Voice all medical benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid for by insurance.

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**Client Signature Date**

**HIPAA Waivers**

How do you want to be notified for your appointments? (Please choose only one.)

\_\_\_\_\_ e-mail

\_\_\_\_ text message (I am aware that text messages can arrive at any time and that it is possible that someone other than me could see this message by looking at my cell phone screen.)

\_\_\_\_\_ I do not want an appointment reminder.

Dr. Buysse can leave detailed, confidential messages at the following phone #s:

\_\_\_\_ home phone

\_\_\_\_\_ Cell phone

\_\_\_\_\_ please do not leave detailed phone messages on any of my phone numbers

**Appointment information is considered to be “Protected Health Information” under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.**

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**Client Signature Date**