YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS. ADDITIONAL SIGNATURES SERVE AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE, AND THAT YOUR INSURANCE COMPANY CAN BE BILLED, SEND PAYMENTS, AND RECEIVE MEDICAL INFORMATION.

SIGNATURE FOR RECEIPT OF HIPAA FORM

PATIENT OR PARENT/GUARDIAN SIGNATURE FOR NOTICE (except in unusual situation of treatment of minor without parental consent, as provided by law). ______________________________

DATE ____________

SIGNATURE FOR ASSIGNMENT OF INSURANCE BENEFITS AND SHARING MEDICAL INFORMATION WITH INSURER

______________________________ DATE ____________

SIGNATURE FOR RECEIPT OF THERAPY AGREEMENT AND PROMISE TO READ IT WITHIN ONE TO TWO WEEKS

PATIENT OR PARENT/GUARDIAN SIGNATURE FOR CONSENT (except in unusual situation of treatment of minor without parental consent, as provided by law). ______________________________

DATE ____________

SIGNATURE FOR ALLOWING WELLNESS PSYCHOTHERAPY TO SEND YOUR BILLING STATEMENTS BY EMAIL

PATIENT OR PARENT/GUARDIAN SIGNATURE FOR CONSENT (except in unusual situation of treatment of minor without parental consent, as provided by law). ______________________________

DATE ____________

PRINT NAME HERE ______________________________

DATE OF BIRTH ______________________________

EMAIL ADDRESS ______________________________