Wellness Associates, PC

Integrating Mind/Body/Spirit

Client's or Authorized Person's Signature:

I acknowledge Wellness Associates, P.C. privacy notice, as required by HIPAA, has been made available to me. One facet of this notice outlines the information which can be released to insurance companies in order to process claims.

Signed: ____________________________________

I authorize payment of medical benefits to the provider for mental health services delivered:

Signed: _____________________________________

Insurance co-payment is due at the time of each visit.

Permission to Treat:

I, ____ give my permission to
(Client's Name)

____ to provide me with mental health services
(Provider's Name) that are within the scope of her license,
Certification, and training.

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