

Kirkland Clinical Associates, LLC

2007 N. Collins Suite 505

Richardson, Texas 75080

Office: (972) 768-1124 Fax: (972) 231-2293

Signature Page

Acknowledgement of Assignment of Benefits, Notice of Privacy Practices and Office Guidelines

Assignment of Benefits

I authorize and request my insurance company to make payments directly to Kirkland Clinical Associate LLC and/or Dan Kirkland MS, LPC-S. I understand that my insurance carrier may pay less than the actual bill for services due to deductible.. I agree to pay my co-pay and deductible as prescribed in my insurance benefit policy. I hereby permit Kirkland Clinical Associates to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payers, or any organizations contracting with any of the above entities to perform such functions.

Client Signature: _____ **Date:** _____
(Parent Signature if Client is a Minor)

Notice of Privacy Practices

I acknowledge that I have received and understand the Notice of Privacy Practices, and understand that a copy of these polices is on the Kirkland Clinical Associates, LLC website.

Client Signature: _____ **Date:** _____
(Parent signature if client is a minor)

Office Guidelines

I acknowledge that I received and agree to the Office Guidelines of Kirkland Clinical Associates LLC and/or Dan Kirkland MS, LPC-S and understand that the same are posted on the Kirkland Clinical Associates LLC website.

Client Signature: _____ **Date:** _____
(Parent signature if client is a minor)

(Revised on 3/11/2016)