Patient Signature Form

_____ _____

Name Date

I ACCEPT THE PSYCHIATRIST-PATIENT SERVICES AGREEMENT

Your signature below indicates that you have read the information in the Psychiatrist-Patient Services Agreement and agree to abide by its terms during our professional relationship and to pay all fees as explained. A copy is provided for your information. If you have any questions or concerns, please talk to Dr. Birdsong's staff as soon as possible.

_____ _____

Patient Signature **Date**

I AUTHORISE THE RELEASE OF MY MEDICAL INFORMATION FOR THE PURPOSES OF OBTAINING PAYMENT FROM MY INSURANCE COMPANY

_____ _____

Patient Signature **Date**

I HAVE READ AND UNDERSTAND THE HIPAA PRIVACY GUIDELINES

Your signature below indicates that you have read the information in the HIPPA Privacy Guidelines sheet and understand your rights. A copy is provided for your information. If you have any questions or concerns, please talk to Dr. Birdsong's staff as soon as possible.

_____ _____

Patient Signature **Date**