Patience D. Stevenson, D.Min., LMFT, LPC

539 Center Street, Bethlehem, PA 18018-5910

Client Communication Permission

Patient name: ____SSN: __________________

DOB: ___________________________

As a client in my practice, from time to time I may need to communicate with you when you are not in the practice. To preserve your privacy, I would like you to indicate your preferred method for me to communicate information to you.

Without specific permission I will not release any of your medical or billing information to another person. In some cases you may wish for another person to have access to your medical information.

In the event that no one is available to answer your phone, I need permission to leave certain types of information on your answering machine or with another person. Please indicate your preference by checking one or more of the items below:

___ Do **not** leave medical information, including appointment reminders, on any answering machine, or with another person.

___ I give permission for Patience D. Stevenson, D.Min., LMFT, LPC to leave any and all medical information pertaining to me, including appointment reminders, on the phone number(s) below:

Cell ________________________________Home ____

___ I give permission for Patience D. Stevenson, D.Min., LMFT, LPC to email me at the following address:

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___ I give permission for Patience D. Stevenson, D.Min., LMFT, LPC to discuss my account balance, insurance coverage/benefits, payment plans, payments and history of my account with the following individual/company listed below:

____

Insurance Company Name

____ _____________________________

Patient Signature Date