**Woburn Pediatric Psychological Services**

**1. Financial Responsibility Statement**

Your health insurance may not pay for the item(s) or service(s) that you or your child(ren) will be receiving today and/or at future visits to WPPS. Health insurers do not necessarily pay for all of your health care cost, they only pay for covered items and services according to your specific plan. The fact that insurance may not pay for a particular item or service does not mean that you should not receive it if your doctor recommends it.

I have read the above notice and understand that I may be responsible for charges not covered by my child's health care plan including co-payments at time of service, and that this waiver will remain in effect until and unless I or my child no longer receives care from WPPS. **My signature below indicates I accept financial responsibility for services not covered by my Insurance Plan.**

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**2. Health Information Portability and Accountability Act (HIPAA)**

My Signature below acknowledges I have received a copy of WPPS' Notice of Privacy Practices under HIPAA.

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**3. Permission to share pharmacy and medical information**

My signature below acknowledges that I grant permission for WPPS to obtain and review all medication information from any other medical entity (physician, hospital and/or pharmacy).

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4. My signature below acknowledges I have received copies of **WPPS Behavioral Health Client Responsibilities**, **Behavioral Health Client Rights** and **Confidentiality Agreement**.

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I acknowledge that the following information is accurate:

Patient Name:

Date of birth:

Address:

Home Phone:

Email:

Signature: ____________________________________ (Patient if >=18 years old or if a fully emancipated minor;

Signature Date otherwise parent)

__________________________________

Printed name of Parent (child under 18)