Woburn Pediatric Psychological Services
7 Alfred Street |2nd Floor
Woburn, MA 01801
Tel: 781-569-6022 | Fax: 781-281-1435

Please initial each line below and sign at the bottom to acknowledge receipt of this consent. Signature with no initials indicates agreement on all lines.

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 the practice. Health insurers do not necessarily pay for all your health care cost, only 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. The following may or may not be covered by your insurance according to your insurer's Summary of Benefits: Vaccines, Co-payments, Co-insurance and Deductibles, Forms, Non-covered Laboratory Testing, and Travel Advice Visits.
Bad Debt Action: If your account is not paid in full or satisfactory arrangements are not made within the allowable time frame, the practice reserves the right to refer the account to a collection agency for collection of the balance. In the event that your account is turned over for collection, in addition to the principal balance owed, you will be responsible for all collection agency fees.

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 the practice.

Please check:

_____I accept financial responsibility for medical services not covered by my Insurance Plan.

2. Health Information Portability and Accountability Act (HIPAA)

_____ I have received a copy of the practice's Notice of Privacy Practices under HIPAA.

3. Permission to share pharmacy and medical information

_____ I grant permission for the practice to obtain, share, and review medication and health information from any other medical entity (physician, hospital and/or pharmacy).

4. Permission to receive communication via Voice or Text messages

_____ I have received a copy of Messenger Communication Terms & Conditions.

Patient Name: _____ D.O.B.:_____

Parent/Guardian/ Printed Name: _____

Parent/Guardian Signature_____

Parent/Guardian D.O.B.: _____ Date: _____