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AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS:

by your insurance.

responsible for incorrect benefits information given to our office. The final responsibility for payment is yours for any fees, or portion of fees not covered or not reimbursed

Ra	lymond H. McCaffrey, Jr., Ph.D. Licensed Psychologist	
Printed Patient Name	DOB:	_ SSN:
	SIGNATURE PAGE you have read the Informed Consent cknowledgment that you have receive	
Item 1: (Please complete this if <u>Cl</u>	ent is a minor. Otherwise, complet	e Item B)
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Note: Two witnesses are required if client signs with an "X"