

Lucy Heggenstaller, M.S.W.,L.C.S.W., B.C.D.
3 Hospital Drive, Suite 308
Lewisburg, PA 17837

ACKNOWLEDGMENT OF CLIENT INFORMATION

I have read Lucy Heggenstaller’s “FINANCIAL POLICIES” and have been informed of her “NOTICE OF PRIVACY PRACTICE”. I fully understand my responsibilities and conditions as a client or as a parent or guardian of a child client.

I authorize Lucy Heggenstaller or her billing staff to send written correspondence or letters to my home.

_____ Yes _____ No *

* Lucy or her staff should mail correspondence to the following address instead:

I authorize Lucy Heggenstaller or her office staff to contact me by phone to modify appointments, or address other issues.

_____ Yes* _____ No

*I prefer that Lucy or her staff use the following numbers listed in order of preference:

If I cannot be reached in person by telephone, I authorize Lucy Heggenstaller or her office staff to leave a message on my voice mail or with a family member.

_____ Yes _____ No

Please list any preferences about messages here: _____

Client signature

Date

Parent or Guardian signature

Date
