Sally Kennedy, Ph.D., LLC
Licensed Psychologist
1160 Milledge Ave.
Suite 130
Athens, GA 30605

706-850-9640; 888-548-1270 (fax)

Patient Name: _____

DOB: _____

Phone: _____

BILLING RELEASE AUTHORIZATION

As a courtesy, I and my staff can send monthly billing statements to a second party (i.e. parent, spouse, etc.) for the sole purpose of payment. Your signature below indicates you have made this arrangement in advance with your second party and they accept responsibility for paying your balance in full each month, unless other arrangements have been made. Please note, should your second party inform us they no longer are responsible or do not wish to receive statements, ***it is your responsibility to pay any and all charges***. Failure to pay balances within 90 days will result in 3% interest fee per month on any outstanding balance. I reserve the right to submit outstanding balances to an outside agency for help in collection of outstanding balances not paid.

I, _____, authorize Dr. Sally Kennedy, LLC, or her representative, to send billing statements to my second party listed below for the sole purpose of payment.

Name: _____

Address: _____

City: _____ State: _____Zip: _____

Fax Number: _____ Phone: _____

I understand that should my second party choose to no longer accept responsibility for payments, any and all charges become my responsibility. I understand I can revoke this authorization in writing at any time. If I revoke this authorization, Dr. Kennedy will no longer send statements to my second party. She shall not be responsible for any statements sent prior to my revocation.

This authorization will expire in one year, following the date of signature, unless revoked in writing prior to that date.

Signature: _____ **Date:** _____

*Note below if Authorization is given on this patient's behalf due to being a minor or unable to sign for the following reasons:

Signature: _____ Date:_____

*Legal Guardian/Personal representative