Behavioral Medicine P.C.

Cynthia Kindgren MS/LCPC
Licensed Clinical Professional Counselor
Owner - Clinical Director

Tara White MSW/LCSW
Licensed Clinical Social Worker
Independent Contract Therapist

I _____ authorize Behavioral Medicine, PC to leave a detailed voicemail and/or email including appointment times, financial responsibility, and information pertaining to my care at the following numbers/email address.

Phone #1: (____)_____

Phone #2: (____)_____

Email Address: _____

Responsible Party's Signature: _____ Date: _____

Address: _____ Birth Date: _____

Witness: _____ Date: _____