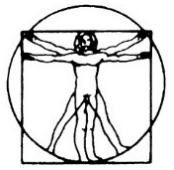


Behavioral Medicine P.C.



*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: _____