Matthew A. Berger, MD, PC

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PRIMARY CARE PHYSICIAN FOLLOW-UP

Name _____ **Date** _____ **Patient Account #** _____
(Please Print) **(Office Use Only)**

It is important to recognize your Primary Care Physician as the coordinator of your health services. This office would like to inform your Primary Care Physician that you are participating in counseling services. No specific information regarding your care will be released without your written consent.

☐ I **agree** Matthew A. Berger, MD, PC or his designee may contact my Primary Care Physician regarding my participation in counseling services.

☐ I **decline** at this time to have my Primary Care Physician contacted regarding my participation in counseling services. I will notify you if I decide in the future to have you contact my Primary Care Physician.

_____ _____
Primary Care Physician Name Primary Care Physician Phone

Patient Signature* _____ **Date** _____

Legal Guardian Name** _____

Legal Guardian Signature** _____ **Date** _____

*If patient is **14 or older**, patient must sign all paperwork and add legal guardians to their HIPAA.

If patient is **13 or under, a legal guardian must sign all paperwork.

If you have any questions, please ask our staff.