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I have received a copy of the Pine Tree Clinic Privacy notice and understand my rights under the Health Insurance Portability & Accountability Act (HIPAA).

Signature\_\_\_\_\_

Printed Name\_\_\_\_\_

Date\_\_\_\_\_

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I have received a copy of the insurance letter and understand Pine Tree Clinic's policy regarding health insurance. I understand how I may submit my claims to my insurance company, if I choose to. I understand that Dr. Zieve is not a Medicare provider.

Signature\_\_\_\_\_

Printed Name\_\_\_\_\_

Date\_\_\_\_\_