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SIGNATURE ON FILE

- I authorize treatment for myself and/or my children.
- I authorize use of this form on all my insurance submissions.
- I authorize release of information to/from all my insurance companies.
- I authorize my Dr. Allender to act as my agent in helping me obtain payment from my insurance companies. I am legally responsible for the amounts due if the insurance company refuses to pay for any reasons.
- I authorize direct payment of insurance reimbursements to Dr. Allender.
- I understand that I am responsible for payment of my account in full.
- I permit a copy of this authorization to be used in place of the original.
- I authorize Dr. Allender to release or obtain medical information from or to person(s) that I designate via telephone or during a therapeutic session.
- I understand that I am responsible for any and all payments of sessions not cancelled 48 hours prior to time scheduled regardless of the reason for the absence.

NAME OF PATIENT(s) _____

SIGNATURE OF PATIENT _____

SIGNATURE OF PATIENT _____

SIGNATURE OF PATIENT _____

SIGNATURE OF PARENT _____

SIGNATURE OF PARENT _____

Parents or guardian sign if patient under 18, BOTH parents must sign if shared legal custody.

TODAY'S DATE _____