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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 Dr. Allender to act as my agent in helping me obtain payment from my insurance company. I am legally responsible for the amounts due if the insurance company refuses to pay for any reasons. I understand there are administrative charges for time spent if required after claims are submitted.
- ☒ 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/to person(s) that I designate via telephone, email, 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 _____

(Both parents sign if patient is under 18)

TODAY'S DATE _____