SIGNATURE ON FILE

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all my insurance companies.
- I understand that I am responsible for my bill.
- I authorize my therapist to act as my agent in helping me obtain payment from my insurance companies.
- I authorize payment direct to my therapist.
- I permit a copy of this authorization to be used in place of the original.

Name (Please Print)_____

Client/Parent Signature_____ Date_____