Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ _____

Signature of patient or parent/guardian of minor. Date

A note about Insurance

As a courtesy, our office will complete and submit your insurance forms to achieve maximum reimbursement to which you are entitled. Please remember that you are ultimately responsible for all expenses incurred. We urge you to read your policy and/or contact your insurance provider so that you are fully aware of coverage and any limitations of the benefits provided.

Cancellation Policy

Your time is reserved especially for you. As a courtesy to other clients and our staff, if you are unable to keep your appointment, we require a 24-hour notice of cancellation.

We charge the full session fee for any failed appointment or appointment cancelled with less than 24 hours notice. This fee will NOT be reimbursed by your insurance provider. Medical emergencies are exempt from this policy.

For the Initial Evaluation a 50% credit card deposit is required to schedule ($150) and will be billed for **any failed appointment or appointment canceled with less than 24 hours notice.**

Please Initial here X _____