JULIE ANN ALLENDER EDD

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**SIGNATURE ON FILE**

* I authorize treatment for myself and/or my children. x I authorize use of this form on all my insurance submissions. x 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. x I understand that I am responsible for payment of my account in full. x 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, text or during a therapeutic session. x 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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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SIGNATURE OF PARENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF PARENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Both parents sign if patient is under 18)

# TODAY’S DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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