

**Consent to Bill Insurance Company**

I, the undersigned, authorize the above named therapist's office to submit claims to my insurance company. If it is the case that my insurance company utilizes a managed care company, my therapist may need to discuss my treatment with a case manager. I understand that my confidentiality will be compromised in such a case. I realize that his/her doing so is a necessity in his effort to secure ongoing care. I also authorize payment of medical benefits to the above named therapist for services provided.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Insured Signature  
(If Different than Patient)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date