AUTHORIZATION FOR FILING INSURANCE

I authorize the release of any medical or other information to process insurance claims. I authorize the payment of medical benefits to Nancy A. Umphres.

Signature_____date_____

AGREEMENT TO PAY FOR TREATMENT
CANCELLED AND MISSED APPOINTMENTS

If the cost of my treatment exceeds my benefits from my insurance company, to the full extent contractually allowed, I understand and agree that I am responsible for full and timely payment.

I agree to cancel appointments no less than twenty-four hours prior to the appointment time. If I do not give twenty-four hours notice and another client does not fill my appointment time, I understand that I will be charged my regular fee.

Illness and other situations beyond my control will be given due consideration on a case-by-case basis.

Missed appointments or appointments cancelled with less than twenty-four hour notice are not covered by most insurance plans. If this is the case, I understand I will be personally responsible for payment.

Signature_____date_____