Authorizations

☐ I acknowledge that I have reviewed and understand Insight Therapy Group's Notice of Privacy Practices.

☐ I acknowledge that I have reviewed and understand Insight Therapy Group's Informed Consent for Therapy Services.

☐ I authorize payment of medical benefits to Insight Therapy Group. I understand that Insight Therapy Group will file my insurance as a courtesy to me, but I am financially responsible and agree to pay Insight Therapy Group within 60-days even if my insurance has not yet paid.

☐ I acknowledge that I have reviewed and understand Insight Therapy Group's Cancellation and No Show Policy.

☐ I acknowledge that I have reviewed and understand Insight Therapy Group's Non-Subpoena Policy.

_____

Name of Client

_____ _____

Signature of Identified Client Date

_____

If signature is not that of the client's, indicate relationship to the client