# Authorization To Bill Insurance

**Clients Name: ___________________________ DOB: _________________**

I, _______________________________ hereby give my consent for CT ABA Services LLC to bill my/my insurance carrier for the services rendered to my child by the above-mentioned provider. In addition, I agree to pay CT ABA Services LLC and deductible or uncovered charge in accordance with my health care plan.

_________________________ ______________________

Parent/Guardian Printed Name Date

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Parent/Guardian Signature