RELEASE OF INFORMATION (ROI) FOR INSURANCE BILLING

I have reviewed and completed the Demographics and Additional Information Forms to the best of my knowledge.

- I authorize my insurance benefits to be paid directly to Inspire Therapeutic Services, Counselor or Clinical Psychologist.
- I Understand if any advice is given or treatment is performed during my visit, this will be charged to my insurance.
- I Understand that I am financially responsible for any balance.
- I authorize Inspire Therapeutic Services to release any information, that I consent to, and this authorization will stay into effect until revoked by the patient.
- I authorize Inspire Therapeutic Services or insurance company to release any information required to process my claims.

Signature: _____ Date: _____

Parent/Guardian Signature _____Date: _____