FINANCIAL AGREEMENT HEALTH INSURANCE /WORKMEN'S COMPENSATION CLAIMS AND MOTOR VEHICLE ACCIDENTS

Welcome to Vitality Therapeutic Massage & Yoga, LLC. In order to familiarize you with the financial policy of this office, please read below how your medical bills will be handled.

EXPLANATION OF INSURANCE COVERAGE

Some insurance policies cover massage, but this office makes no representation that your policy does. Insurance policies can differ greatly in terms of deductible and percentage of coverage for massage care. With the variance from one insurance policy to another, you, the patient, are personally responsible for the payment of your deductibles, as well as unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance company(ies) in a timely manner. In the case that your insurance denies payment we will notify you via email and we will charge the credit card on file on a date that we have agreed upon after all efforts by our staff and yourself to collect payments have been exhausted.

PAYMENT ARRANGEMENTS

Any unpaid balance will be considered past due after 30 days and may incur a late fee.

ASSIGNMENT OF BENEFITS

Attached is an "Assignment of Benefits" form for you to sign. This form instructs your insurance company to send their payments directly to this office. Please sign all copies of this form. If your insurance carrier sends you payment for services incurred in this office, you shall send or bring the full payment to our office within 30 days upon receipt.

RELEASE OF INFORMATION

If your insurance company requires medical reports to document your treatment and progress, your signature below authorizes the release of medical information necessary to process your claim. Please ask if you have any questions concerning the financial policies of this office. Once again, we welcome you to Vitality Therapeutic Massage & Yoga, LLC.

I have read and agree to the above and I authorize payment for only the items outlined above via the following credit/debit card: Credit card number, exp. date, security code:

Card #_____

Expiration date:_____Security code:_____

Your signature:_____

Date signed:_____

Insurance Company:_____

Insurance Company's Fax number:

Claim number:_____

Agent's Name:_____

Agent's Phone:_____

Assignment of Benefits You authorize payment to be paid to the provider shown above for insurance benefits otherwise payable to me. Insurance payments are normally made within 120 days, if we have not received payment within that time frame and all of our combined available efforts to obtain payments have been exhausted you understand that you are financially responsible to the named provider for the charges. I certify that the information furnished in support of this claim is true and correct and I authorize payments to made directly to (practice name).

Signature:_____

(the insured's or the insured's legal representative) (Required)

Date signed:_____

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