

## FINANCIAL AGREEMENT HEALTH INSURANCE

We would like to take a moment to welcome you to our office and to assure you that you will receive the very best care available for your condition. In order to familiarize you with the financial policy of this office, we would like to explain how your medical bills will be handled.

### EXPLANATION OF INSURANCE COVERAGE

Some insurance policies cover Massage and/or Acupuncture, 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 and/or Acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be 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 exactly 14 days after we send that email.

### PAYMENT ARRANGEMENTS

We require that you pay your co-pay on the day the services are performed. Any unpaid balance will be considered past due after 30 days.

### ASSIGNMENT OF BENEFITS

Attached is an "Assignment of Benefits" form which we would like 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 immediately 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.

### VOLUNTARY TERMINATION OF CARE

If you suspend or terminate your care at any time, your portion of all charges for professional services are immediately due and payable to this office. All services rendered by this office are charged directly to your credit card on file, and you, ultimately, will be personally responsible for payment, regardless of your insurance coverage.

We hope that this answers any questions you might have concerning the financial policies of this office. Once again, we welcome you to our office, and will be glad to answer any further questions that you might have.

I have read and agree to the above and I authorize payment for only the items outlined above via the following credit/debit card: \_\_\_\_\_

Please give your credit card to the desk person to put on file at your first visit.

Your signature: \_\_\_\_\_

Date signed: \_\_\_\_\_

Assignment of Benefits

Provider information

(where payment is to be sent)

Facility/agency or provider name: Julie Madsen / Permanent Vacation Bodywork LLC

Federal Employer Identification number 84-3766009

Payment address: PO Box 17431

City: Portland

State: Oregon

Zip: 97217

Phone number: 971-344-7895

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 60 days, if we have not received payment within that time frame 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 made directly to Julie Madsen, Permanent Vacation Bodywork LLC.

Signature: \_\_\_\_\_

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

Date signed: \_\_\_\_\_