

AUTHORIZATION

Please take a moment to carefully read the following and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session I will immediately inform the practitioner so that the pressure and or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified health specialist for any mental or physical ailment that I am aware of. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have made known my medical conditions and have answered all questions and have answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there should be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances will result in termination of the session, and I will be liable for payment of the scheduled appointment.

I hereby give permission to Allergies, Aches & Pains to release any private health information necessary in treatment, payment or health care operations. I authorize the use of my signature on all insurance claim submissions. I understand I may revoke this release only in writing. I understand that this office does leave voicemail messages if they are unable to contact patients, unless instructed in writing not to do so.

I hereby understand that payment is expected when services are rendered unless other arrangements are made in advance. I also understand that I am responsible for all bills and any collection expenses incurred at this office.

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Allergies, Aches & Pains all insurance benefits, if any, otherwise payable to me for services rendered.

I fully understand and agree that the insurance policies are an arrangement between an insurance carrier and myself. I understand I am financially responsible for all charges whether or not they are paid by insurance, and I may be billed if necessary for additional costs incurred in the collection of these accounts. I understand that it is ultimately my responsibility to know and understand my insurance plan.

I also understand that insurance benefits are not a guarantee of insurance coverage.

I certify that I have read and understand the above information and that it is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient's/Guardian's Signature _____ **Date** _____

PLEASE PRESENT YOUR INSURANCE CARD AND A PHOTO ID

A copy will become part of your medical record.

ALLERGIES, ACHES, & PAINS CHIROPRACTIC & ACUPUNCTURE CENTER, Ltd.

Patient Missed Appointment Policy Massage Therapy

It is our wish that each and every one of our patients receive the very best care and service possible. Your Treatment Program consists of a recommended series of treatments. If you do not follow this plan, then you will not receive the desired results.

If we did not request that you meet all your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few guidelines that we ask you follow:

1. Meet all of your scheduled appointments.
2. If you are unable to keep your appointment, please call us and let us know in advance so that we may fill your appointment time with someone on the waiting list.
3. With the exceptions of unexpected emergencies, we request that you notify us 24 hours in advance as to any appointment changes. Appointment confirmation calls will be made 24-48 hours in advance of your scheduled appointment.
4. If you are late for an appointment, your appointment will still end at the same scheduled time, as a means to respect the time of the next appointment. The fee structure will remain the same.
5. If you miss a scheduled massage therapy appointment you will be charged for your scheduled session. This charge will be added to your account & charged to your credit card on file at the time of your missed appointment.

I have read, understand, authorize and agree to follow the above policy.

Patient's Name: _____

Signature: _____

Staff Witness: _____

FINANCIAL POLICY

Communication with our clients regarding our financial policy assists us in providing the best possible service to you. Please read the following. Your initials and signature are required. Thank you.

- _____ Private Pay/Cash Patient – (clients without BC/BS insurance) Full payment is required when services are rendered to continue treatment OR payment arrangements need to be agreed upon.
- _____ Insurance Reimbursement – Clients are required to contact their insurance company to verify their deductible status and the amount of coverage for chiropractic, acupuncture and massage therapy available to them. We will also be contacting your insurance company to verify your coverage. It is important to remember that what the insurance tells us is not a GUARANTEE of payment from them.
- _____ Deductible and Co-payment - If you have not met your deductible, you will be required to pay the full amount of each visit until you have met it. We require your co-payment or co-insurance at the time of service. If you do not know what your co-insurance is, a minimum of 20% is due at the time of service. Any charges that your insurance company does not pay for or denies will be the patient's responsibility.
- _____ Purchasing Products – Payment for all products is the patient's responsibility. Payment for products is due at the time of purchase. As a courtesy to you, we will bill your insurance company. If your insurance company does pay for the product, we will credit/refund your account.

AGREEMENT TO PAY

I understand that the agreement with my health insurance is an agreement between them and me. I take full responsibility for payment of all charges for professional services rendered. I understand the financial policy detailed above. I understand that I am responsible for all charges regardless of my existing medical coverage. NSF check will be charged a \$25.00 fee.

Consent for Treatment/Release of Insurance Assignment Medical Information.

YES____ NO____ I authorize any and all therapy services that the provider feels necessary.

YES____ NO____ I assign payment of medical benefits directly to Allergies, Aches & Pains.

YES____ NO____ I authorize Allergies, Aches & Pains to leave voicemail messages regarding my appointments. Should I decide that I no longer wish to have messages left, I understand that a written request must be made.

YES ____ NO ____ I hereby authorize Allergies, Aches & Pains to release to my insurance company, health plan, or insurance group, any medical records or information concerning the treatment to obtain reimbursement on my behalf for the treatment or service provided by Allergies, Aches & Pains. I understand that I may revoke the consent to release information to third parties at any time and that the provision of services is not conditional on my agreement to disclose information to the parties. If I revoke my consent, I will be responsible for paying for all services rendered by Allergies, Aches, & Pains.

I have read , understand and agree to this financial agreement.

SIGNATURE

DATE