RELEASE OF RECORDS/PAYMENT AGREEMENT

PATIENT INFORMATION ☐ MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED ☐ OTHER

NAME (Last, First, Middle)		
ADDRESS (No., Street)		
CITY	STATE	ZIP CODE
HOME PHONE	WORK/CELL PHONE	

RELEASE OF RECORDS:

To Provider of Services: Structural Healing Massage and Bodywork, Inc. I hereby authorize you to release to any attorney, physician, or insurance company, involved in my case, any medical or other records or information necessary to process my claim. These records are to be utilized for the ultimate recovery of benefits in my case for the injury/illness sustained on (date) _____.

PATIENT INITIAL HERE:

_____

PAYMENT AGREEMENT:

I understand that my insurance contract is an agreement between the insurance company and myself. I acknowledge that your office is willing to prepare the necessary reports and assist me in collecting from the insurance company that which is due to you for my medically necessary care and treatment.

I agree and acknowledge that I am ultimately responsible to you for payment of any balance due, including unpaid deductible and/or unpaid percentage amounts due to you according to my policy coverage, in the event you are unable to collect from my insurance carrier or attorney in the case where you are holding an attorney lien on my behalf.

I understand that 24 hours notice is required for cancellation of appointment, and I will be charged for missed appointments without proper notice at 50% of normal rate.

I understand I may elect to be billed monthly or at the time of each visit for the balances due to you from each visit. I elect to pay by Check ___ Cash ___

PATIENT INITIAL HERE:

_____

Note: It is illegal to bill the patient for any balance if W/C is paying the claim.

PATIENT'S SIGNATURE **X**	DATE

PROVIDER'S SIGNATURE **X**	DATE