Health Insurance Policy

I _____ (print name) do hereby give full permission and authorize *Massage By Carey*,

to help me seek reimbursement from _____(name of insurance company) for services rendered by *Massage By Carey*. This may include sharing and transferring my health records to process my request.

By signing this document, I agree to the following statements below:

- I understand that I am responsible for understanding information about my health insurance policy and will verify coverage *prior* to seeking reimbursement for massage therapy services.
- I understand *Massage By Carey* **does NOT offer full service insurance billing**. *Massage By Carey* will provide the necessary information for the patient to submit the provided claim form (CMS1500) directly to the insurance carrier for reimbursement.
- I also understand that my insurance company and related policy plan may offer benefits for services provided at *Massage By Carey*, but that such benefits and/or the submission of this form do not necessarily guarantee payment for those services.
- I understand that the policy of *Massage By Carey* requires payment in full for all services rendered at the time of visit.
- I understand a service fee of 5% will be applied to the total reimbursement amount and is to be paid directly to *Massage By Carey* prior to claim submission.
- I understand that insurance reimbursement services are completed at the end of every month.

I will provide the following information to Massage By Carey:

☐ Copy of insurance card (front & back)
☐ Written referral for massage therapy services from doctor
☐ Diagnosis Code (ICD-10 Billing Code) can be provided on written referral
☐ Prescription for massage therapy services (not mandatory): Instructions for a specific protocol from your doctor (i.e. TBD, 2xwk for 4 wks.)

I understand the above information and agree that my health history and related information was completed correctly to the best of my knowledge and understand that it is my responsibility to alert *Massage By Carey* of any change in my medical status or insurance coverage.

The undersigned does agree to observe and abide by all of the statements made above.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____