The Massage Collective

Boulder Massage & NeuroMuscular Therapy

Insurance Information

Name _____DOB_____Date _____

Primary Insurance Co._____

Subscriber #_____Group #_____

Insured's Name_____ Insured's DOB_____

Consent to Treatment

Please **initial** each statement.

____ I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examinations, and treatment at The Massage Collective.

Release of Records

____ I hereby authorize the release of medical records, or information necessary to process my claim, to my insurance company, adjuster, or attorney.

Financial Responsibility and Assignment of Benefits

____ I understand I will be charged for any missed appointments and any appointments cancelled with less than 24 hours notice.

____ I hereby assign to this massage practice all monies to which I am entitled for massage expense relative to the service rendered by this practice, but not to exceed my indebtedness to said massage practice. It is understood that any monies received from the above named insurance company(s), over and above my indebtedness, will be refunded to me or my insurance company(s), as it is determined to be appropriate, after my bills are paid in full. I understand I am financially responsible to The Massage Collective for charges not covered by this assignment including charges for no shows or late cancels. In the event I default, I agree to pay, whether or not legal proceedings are instituted, a reasonable COLLECTION FEE which shall be 20% of the principal balance for any debt incurred hereunder and to pay all reasonable LEGAL COSTS as a result of my default.

I certify that I have read this form and understand its contents.

_____ Date _____

(Patient – 18 or older – or other legally Authorized Person)

health · recovery · rehabilitation

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