POLICIES and AUTHORIZATION

Payment Policy

YOU ARE ULTIMATELY RESPONSIBLE FOR THE PAYMENT OF YOUR ACCOUNT.

Patients with insurance: If your medical insurance policy provides benefits for massage therapy we will be happy to submit a claim to them on your behalf. You are expected to pay your estimated portion at the time services are rendered, this may be in the form of co-pays, co-insurance, and/or deductibles. Your estimated portion will be calculated by the benefit information we receive from your insurance company. A benefit quote is not a guarantee of payment. Patients who are being treated on worker's compensation or motor vehicle collision claims are required to get us the proper insurance information and referrals:

Worker's Compensation: Worker's compensation does cover massage therapy if your claim has been approved and is currently open. If the claim is not allowed or it is denied it is YOUR responsibility to pay the outstanding balances.

Motor Vehicle Collision: Your auto insurance company will pay for necessary massage therapy if you had "PIP" (Personal Injury Protection) coverage included in your policy at the time of the collision. You must file a claim with your auto insurance company, and also complete and return a PIP application to them before they will issue any payments towards your account.

Patients when insurance DOES NOT apply: We offer a time of service discount for patients with limited insurance benefits or for patients with no insurance coverage at all for massage therapy. Ask for details.

I have read the above policy of* SYNERGYwellness *and fully understand that I am responsible for the payment of my account. ****Initial*** _____

Cancelation Policy

We would like to strongly stress the importance of receiving massage therapy regularly, especially for the rehabilitation of an injury. If you receive treatments on schedule, the success and benefits will be greatly increases and recovery time will be quicker.

In respect to you and your time, and us and our time we will need a minimum of 24 hour notice of cancellation of appointments (with the exception of emergencies). If we are not notified in a timely manner, you will be charged a cancelation fee of $40.00 and treatment will not resume until payment is received. IF TWO OR MORE APPOINTMENTS ARE LATE CANCELLED OR MISSED WE WILL CANCEL ALL STANDING APPOINTMENTS UNTIL PAYMENT IS RECEIVED.

I have read the above policy of* SYNERGYwellness *and fully understand that I am responsible for the timely cancelation of my appointments. ****Initial*** _____

Massage Therapy Treatment

My treatment *may* involve the use of oils, lotions, hot/cold pack application necessitating the need for me to remove some or most of my clothing. During this time, I understand I will be draped appropriately with linens for warmth and privacy. ONLY the specific area being treated will be undraped. If a session necessitates removal of clothing, and I prefer to remain clothed, I will inform my practitioner. I understand that the body treatments given by my practitioner are for relaxation, stress reduction, relief from injury related pain and/or beautification. I further understand that **SYNERGYwellness** practitioners DO NOT diagnose illnesses or prescribe medical or pharmaceutical treatment. It has been made clear to me that it is my responsibility to contact a licensed health care provider for any medical or health condition. It is my choice to receive massage therapy, and I have provided accurate information concerning past or current health conditions. I agree to report any changes in my health as they arise.

I have read the above disclaimer of* SYNERGYwellness *and fully understand that I am responsible for disclosing any changes in my health information to my provider. ****Initial*** _____

SYNERGYwellness Studio | 621 Pacific Avenue Suite 100 Tacoma, WA 98407 | 253.209.7855 | 253.320.2115

POLICIES and AUTHORIZATION continued

Right of Refusal

We had the right to refuse service to anyine at anytime without explanation.

Notice of Privacy Practices Acknowledgement (HIPAA)

We keep record of the massage therapy services we provide to you. You may ask to see and copy that reord. You may ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or requires us to do so. You may also see your record or get information about it by contacting your **SYNERGYwellness** practitioner.

Our notice of privacy practices describes in more detail how your health information may be used and disclosed and how you can acccess your information. A copy of the notice is available upon request.

Authorization to Bill Insurance

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer you the cause of action that exists in my favor against any such company and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance company's proceeds, whether it is all or part of what is due, I personally owe and agree to pay to you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in the state of Washington.
5. I further agree that this authorization and assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This authorization for assignment will be in continual effect until revoked by both parties.

* I have read and I understand the above content, including Payment Policy, Cancelation Policy, Notice of Massage Therapy Treatment, Right of Refusal, Notice of Privacy Practices & Authorization to Bill Insurance. I agree to comply with all that is stated above.

Patient Name

Patient Signature (if minor, parent or guardian signature)

Today's Date

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