

## FINANCIAL AGREEMENT

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Massage Therapy is not covered by Medicare or any Medicare supplement programs.  
We do not accept Medical Coupons.**

### **Please read important financial responsibility agreement and sign below:**

In fairness to our other patients and to us, 24 hour notice is required for cancellation of an appointment, or you will be **charged a \$40 fee** for the time booked. In the case the patient misses more than three appointments in a 12 month period; the patient will no longer be a patient of A Better Way Massage, LLC.

We will be glad to bill directly to and accept payment from the insurance company. It should be understood that all services are charged to you, the patient, who is legally responsible for payment. Most insurance companies require massage be medically necessary to recover from an injury or illness, thus not maintenance massage in nature. In the case patient treatments are deemed non medically necessary, not a covered service under member benefits, or member benefits have been exhausted, patient agrees to pay for all services or supplies in full. Patient also agrees to pay all collection costs including, but not limited to reasonable attorney fees, late charges and litigation costs in the event of any breach, including failure to timely make any required payments.

By signing below, I acknowledge that I was given a copy and read the **NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (HIPPA)** and was asked questions. I understand a copy of the notice is available at any time.

I hereby authorize the release of my medical records to the above insurance company for the express purpose of payment of my medical bills incurred in this office. I hereby authorize the insurance company or attorney to remit payment directly to this office.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_