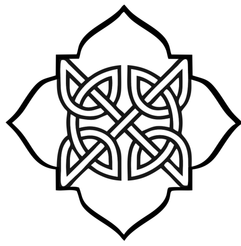


Avalon
HOLISTIC THERAPIES

HEALTH INSURANCE INFORMATION

Client's Name ______________________________ DOB ____________

Referring Physician______________________________ Physician's Phone # ____________________

Insurance Information:

Insured's Name______________________________ Insured's DOB________________

Name of Insurance ______________________________ Phone Number ________________

Address ____

Employer's Name______________ Group ID#______________________

Claim or ID # ________________ Allowable Benefits__________________

Yearly Deductible__________________ Has it been met? ______________

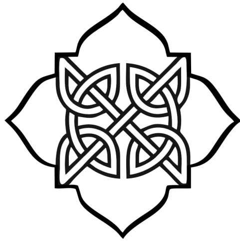
Co-Pay____________________________ Need Prescription? ______________

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize Avalon Holistic Therapies, LLC to furnish my records to the insurance company or an attorney for the purpose of obtaining payment on my account for service provided to me. In addition, the undersigned hereby authorizes payment directly to Avalon Holistic Therapies, LLC for all Massage Therapy benefits otherwise payable to the undersigned or the client.I understand that I am responsible for all charges incurred at Avalon Holistic Therapies, LLC regardless of my insurance coverage.

Your signature________________________________

Date __________



HEALTH INSURANCE BILLING AGREEMENT

I, ___________________________________ (the client) agree to pay in full all amounts due to Avalon Holistic Therapies, LLC (the provider) for services rendered if, for any reason, the insurance company has not submitted payment within six months from the initial billing date.

In the case the insurance company submits payment to Avalon Holistic Therapies, LLC, after I, the client, have paid, Avalon Holistic Therapies, LLC will sign over the insurance company check within two weeks of receiving the check from the insurance company.

In the case the claim goes to settlement before six months from the billing date and Avalon Holistic Therapies, LLC has not been paid in full for services rendered, I, the client, agree to have the unpaid balance paid to Avalon Holistic Therapies, LLC by my attorney from the settlement funds before I receive payment.

I, the client, also agree to pay any balance due for services rendered if the insurance company does not pay the full and customary fee.

____ ______________________

(Client Signature) (Date)

____ ______________________

(Representative of Avalon Holistic Therapies, LLC) (Date)

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Portland, OR 97225
(503) 544-2463